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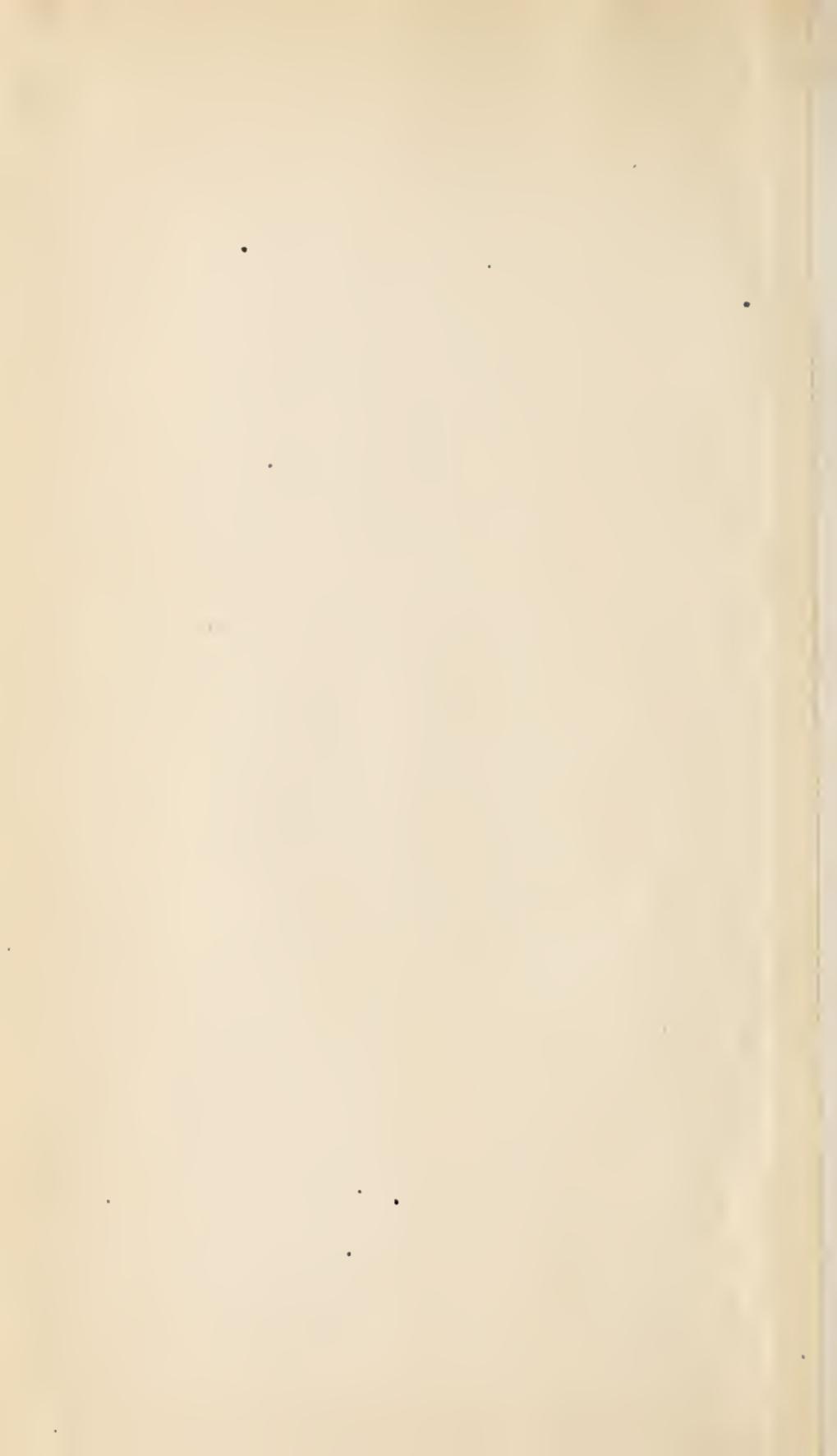
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DERMATOLOGY  
A QUARTERLY JOURNAL  
OF  
SKIN AND VENEREAL DISEASES

EDITED BY

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*FIFTH VOLUME*

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PHILADELPHIA:  
J. B. LIPPINCOTT & CO.  
LONDON: 16 SOUTHAMPTON STREET, COVENT GARDEN.

1879

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*H. Braeger, M.D.*

DR. DUHRING'S CASE OF  
INFLAMMATORY FUNGOID NEOPLASM.

# ARCHIVES OF DERMATOLOGY.

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JANUARY, 1879.

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## ORIGINAL COMMUNICATIONS.

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### A CASE OF INFLAMMATORY FUNGOID NEOPLASM.\*

BY LOUIS A. DUHRING, M.D.,

Professor of Skin Diseases in the Hospital of the University of Pennsylvania, Dermatologist to the Philadelphia Hospital, Physician to the Dispensary for Skin Diseases, Philadelphia, etc.

THE case which I have the honor of bringing before the Association in the present communication represents so rare a disease and is of such interest, that I shall not occupy the time with introductory remarks.

The patient is a highly-intelligent lady, 58 years of age, the mother of four children. She is of large frame, and has always inclined to be fleshy, her weight at present being one hundred and seventy-four pounds. She first presented herself to me in October, 1877, ten months ago, when I noted the following history, which I transcribe verbatim from my note-book.

#### PREVIOUS HISTORY.

Her general health has always been excellent. The catamenia ceased normally at the age of forty-six. She has never had any disease of the skin until the present occasion. Her father was healthy, and died of some acute disease; her mother, at the age of seventy-eight, was attacked with a cancer, which proved fatal. She has no brothers or sisters. Her children (four in number) are all in good health. In August, 1876, fourteen months ago, on one occasion, when very much over-heated, she indulged in a cold bath which was followed the next morning by severe stiffness and pains throughout the whole body. Two days later she again became excessively heated, when the skin of the entire surface appeared very red, for which condition she was bathed with salt and water. Three hours

\* Read before the American Dermatological Association at its second annual meeting, at Saratoga Springs, August, 1878.

afterwards an extensive rash, in the form of large, elevated, reddish wheals, made its appearance, which remained twenty-four hours. There was no gastric disturbance. This affection was without doubt urticaria. After feeling entirely well for a fortnight, there appeared, without premonition, a quite different eruption, characterized by a red surface with minute, pointed vesicles, which desiccated on the third day, leaving small crusts. It was universal. The attack terminated in about a week in a general scaling of the surface. From the description it is more than probable that the disease was a general, acute, vesicular eczema. About a week later she was awakened out of a sound sleep by a most violent attack of itching, unaccompanied by any eruption, invading the whole integument. The following morning she experienced nausea and general debility, together with repeated attacks of the itching which would frequently announce themselves. This pruritus, for at no time was there any efflorescence, lasted three days and nights, and is described as having been most distressing. It was treated, without favorable result, with baths. A fortnight later (about October 10, 1876) the first lesion of the disease of the skin we are considering was noted. It manifested itself as a "red spot" on the right side of the forehead, above the eyebrow, where the largest lesion now exists. It came suddenly through the night. She had retired in good health, free from any sign of cutaneous disturbance, and awoke in the morning to find, greatly to her surprise, this marked red spot. When first seen it was of a dull red color and not at all inflammatory in nature, perfectly circular in outline, very sharply defined, and the size of a silver dime. To the touch it was as smooth as the surrounding healthy skin, and was not at all thickened. It looked like a superficial burn; so much so that her friends were continually asking how she had burned her forehead. There were no subjective symptoms. No treatment was instituted at this time.

The lesion grew very slowly during the following months, but varied from time to time considerably in color; occasionally it would become so pale that she thought it was about disappearing, when, unexpectedly, it would again assume its deeper color. These changes of color were quite marked, and had the peculiarity of always taking place rapidly, often in the course of a few hours. The spot retained its circular form for five or six months, by which time it had gradually attained the size of a silver half-dollar. After this period, during the summer of 1877, it altered its shape and became ovalish. It did not, however, change in any other way until August, 1877 (at which date it had existed almost a year), when it began to rise slowly, unattended by itching or pain. She states, had she not seen the lesion or felt it with the hand, she would not have been aware of its existence, so devoid was it of all sensation. It rose from the surface in form like a boil, but other than its form possessed none of the characters of a boil. By the end of a fortnight it had risen a full half-inch above the level of the surrounding skin, to the height which it now possesses. The further developments

about this patch, to which I shall presently refer, have all made their appearance within the past two weeks, having manifested themselves from day to day with great rapidity, unattended by heat, itching, or other subjective symptom.

To return to the date of the first appearance of the lesion which we have just been considering, we are told by the patient that on the following morning nine distinct wen-like, rounded elevations, the size of half-cherries, appeared here and there upon the scalp. They came very unexpectedly and suddenly, within a day, but did not reach their ultimate size for about ten days. They were from the beginning very hard to the touch, "feeling like wens or lumps of gristle under the skin." They were not adherent to the tissues beneath, but could be moved about, and were in no degree painful, even upon pressure; but they itched intensely from the beginning until they attained their full size, when this symptom entirely ceased. They disappeared gradually, without treatment, in the course of three weeks, becoming from day to day softer and flatter until nothing remained to mark their former existence, the skin showing no trace of disease or of scar. Some six months after this another attack of the same kind appeared on the scalp, which was similar in every particular to that just described. Two weeks ago a third attack occurred, consisting of one lesion only, situated in the median line of the scalp, near the forehead. It pursued the same course as the former ones.

In June last (four months ago), the lesions on the abdomen and those on the under surface of arm, just beyond the axillæ, made their appearance. They came suddenly, in the course of twenty-four hours, unaccompanied by any subjective symptoms; when discovered they had already reached the size of silver quarter-dollars. She is positive concerning their sudden manifestation. They were, when first observed, circular in form; of a dull pinkish color; on a level with the surrounding healthy skin, and smooth. They increased rapidly in size, enlarging from day to day until they obtained their present dimensions. On one of the patches on the abdomen there appeared suddenly, about a month since, four indistinctly-defined, split-pea sized, hard purplish tubercles. They rose from the surface in the same manner as the original pointed lesion on the forehead, but have shown no disposition to grow.

About the 1st of July (three months ago) three new lesions appeared, situated as follows: one in the left groin, just below Poupart's ligament; another upon the anterior surface of the right thigh; and the third in the left popliteal space. These, like the preceding, came suddenly, within twenty-four hours. When she first noticed the one on the thigh and that in the popliteal space they were both elevated, and were about their present size. These two were the only lesions which were elevated from the beginning. That in the groin was the size of a dime, circular, on a level with the healthy skin, and grew slowly, two months elapsing before it reached its present proportions. These three lesions have always

been quite sensitive, pressure, heat or cold or other external agency irritating them. Some four weeks after the patch in the groin had manifested itself there came in its centre a hard, gristly, whitish, glistening tubercle, which grew gradually, occupying six weeks in arriving at its present size. It continued of a grayish, pinkish color until it reached its full size, when it by degrees assumed a reddish color, and then became softer in consistence. The patient is not aware when the several lesions over the spinal column and on the buttocks made their appearance ; they came insidiously.

#### PRESENT CONDITION.

The lesions existing at the present date (Oct. 25, 1877) may be described as follows: The most conspicuous constitute a patch situated on the forehead, extending from the median line to the external canthus of the right eye, thence to the ear, and from scalp to eyebrow, thus involving the greater part of the right side of the forehead. The general surface of the patch is irregularly uneven, owing to certain prominent elevations and depressions in the form of tumors, tubercles, and furrows. The color varies from a dull violaceous pink to a pale raspberry-red. Here and there are observed small, thin, superficially-seated blood crusts.

Viewing the patch more critically, it is seen to be composed of five lesions, more or less merged into one another. In the centre there rises conspicuously prominent above the rest a firm conical or nipple-shaped tumor the size of a large half-cherry, with a broad base. This is the original lesion, and, it will be remembered, is of one year's duration. It is fairly circumscribed ; is raised a full half-inch above the level of the surrounding healthy skin ; and is of a pale raspberry-red color, with a glistening light on its summit. To the touch it is soft, and gives the impression of containing fluid. Puncture with a fine knife, however, shows that such is not the case, a few drops of thick blood only oozing forth. The tumor is quite painless even upon pressure, and is unaccompanied by itching, burning or pain.

The next lesion to be considered is that which followed the one that has just been described, and is of four months' standing. It will be borne in mind that this patch rose up quite prominently a fortnight ago, and then suddenly returned to its present state. It adjoins and is connected with the original tumor, and consists of several indistinctly-defined elevations which have merged into one another, forming a patch of disease about the size of a silver half-dollar, with an irregularly-rounded outline extending from the line of the scalp in a semicircular manner to the eyebrow, where it joins a third patch. Its surface is uneven and tuberculated, and exhibits several conspicuous furrows, one in particular being quite deep. Adjoining this lesion there exist three large split-cherry sized tubercles, which have coalesced at their bases. Merging into these tubercles, just above the eyebrow and involving the temporal region, we meet with the last and largest tumor. It is of a distinctly roundish form ; the size of a silver half-dollar ; sharply circum-

scribed, especially around its lower border over the temporal region, rising abruptly here an half-inch above the sound skin. It is firm and fleshy to the touch and of uniform consistence, with no sense of fluctuation. Taken between the fingers, it can be picked up and raised partially from the tissues beneath. It is freely movable with the surrounding healthy integument, and readily glides over the bone. It is a solid and heavy tumor for its size, and drags down the eyebrow and presses upon the eyelid so as to almost close the eye. Its color is a yellowish raspberry-red, deeper in tint than the neighboring lesions ; its surface is smooth and glistening. Pressure exerts but little influence in dispersing the blood. There are no enlarged blood-vessels upon its surface.

Towards the scalp the original lesion and that just referred to merge into each other, and, after becoming flatter, pass imperceptibly into two flat, dull-pinkish patches within the border of the scalp, which are of recent date, having appeared only three days ago. They are olive-sized and shaped, joined together, well defined, raised about a line, quite soft and supple, and can be readily pinched up between the fingers. They are without subjective symptoms. Over the left side of the forehead and over the face and neck generally there are here and there small, mostly split-pea sized, irregularly distributed, erythematous, reddish, violaceous, and yellowish patches, for the most part faint in color and indistinct in outline. The surface of the skin is harsh, and inclines to be slightly scaly. These lesions, she notes, come and go from time to time. The same kind of lesions are found in number over the sides of the trunk, upon the abdomen, and on the flexor surfaces of the thighs as far down as the knees, varying in size from a split pea to a silver half-dollar, irregularly rounded or ovalish in shape, and more sharply defined than on the face and neck. They vary in color according to the stage of their development, the more recent ones being of a pale violaceous color, and the older ones of a pale yellowish-red or salmon color. The skin here, as on the face, is harsh and slightly scaly. The patches somewhat resemble irritated tinea versicolor or squamous eczema.

On the inside of the right arm, just below the axilla, there exists an ovalish patch as large as a child's palm, which, it will be remembered, appeared in July last, four months ago. It is very slightly raised above the level of the skin ; is sharply defined ; possesses a dull-pinkish color ; is covered with scanty, minute whitish branny scales ; and exhibits the natural lines of the skin in an exaggerated state. In the centre of the patch exist four split-pea sized, firm, violaceous, tubercular elevations, identical with those upon the forehead. The patient states that they appeared yesterday, and that they are of the same character as those on the abdomen which have existed for weeks. Another lesion, olive-shaped and sized, running parallel with the natural lines of the skin, similar in all respects to that just described, but without tubercles, exists on the posterior fold of the left axilla.

On the abdomen, between lower border of mammae and umbilicus, there are four discrete, circumscribed patches, and one very irregularly-shaped patch made up of a number of smaller, more or less discrete lesions. On the right side of abdomen, three inches to the right of the umbilicus, there is an oval, dull-rose colored patch, as large in outline as a goose egg, which runs transversely across the trunk. It is well defined, except upon its upper border, where it is notched or indented, which gives it a "kidney shape." It is elevated a line above the surrounding skin, and is covered with a scanty film of whitish, branny scales. Upon the upper border there are three split-pea sized, firm, smooth, pale-purplish, well-formed, rounded tubercles, arranged in a line, and situated so close to one another as to almost touch. They look and feel not unlike tubercles of fibrous or connective-tissue carcinoma. They are very similar to those existing in the patch on the right arm, already described.

On the left side of the abdomen we find three lesions. One is an olive-sized and shaped patch, running transversely across the trunk, beneath the left mamma, with the general characters of the large lesion on the right side of abdomen. The second, situated three inches above the centre of Poupart's ligament, is ovalish in form, running parallel with the lines of the skin, and is the size of a child's palm. It has a smooth, glistening surface, and a mottled, violaceous-red color, and shows a tendency to clear away in the centre and to assume an annular form. The third lesion is a large hand-sized patch, occupying the region between the left mamma and the crest of the ilium, composed of scattered, variously-sized, multiform lesions, varying in character. They are split-pea and bean-sized and shaped; indistinct in outline, so much so that their shape can scarcely be defined; many of them have, moreover, coalesced, and have formed irregularly-shaped patches. They are for the most part elongated lesions, from a half-inch to an inch and a half in length and about a half-inch in width. The most conspicuous, some three or four, are perceptibly elevated in the manner of wheals; are firm; perfectly smooth; pale-purplish in color; and have a ridgy, lumpy feel. In addition to these lesions there are a dozen or more ovalish, slightly-pigmented, dirty-yellowish, salmon-colored, indistinctly-defined spots on a level with the healthy skin. These lesions are also found here and there over the whole trunk and on the thighs. According to the patient, most of them have existed for several months, and have undergone but little change.

We now come to the patch situated in the upper part of the left groin, at the junction of the anterior face of the thigh with the trunk. It is irregularly-ovalish in shape; the size of a large hen's egg; clearly defined, with a distinctly-elevated, rounded, thick, fleshy upper border raised a full quarter-inch; smooth; violaceous; and manifests a disposition to clear away in the centre. It has not changed materially within the past two months. During the summer it was tender and felt sore, but it never became excoriated.

In the centre of the back, directly over and running parallel with the spinal column, at the fourth dorsal vertebra, there is a raised, pale-reddish, olive-sized and shaped patch. It is soft and supple, and can be picked up, but has a harsh surface, and shows the natural lines of the skin very plainly. It has existed four months, and has changed but little. Over the upper part of the right buttock there are four patches identical with those just described.

On the thigh there exists only one conspicuous lesion, situated on the anterior surface of the middle of the right thigh. It is circular; the size of a silver half-dollar; raised three-eighths of an inch; sharply circumscribed; of a pale raspberry-red color; and has a papillomatous, warty, lobulated, raspberry-like surface, covered with adherent thin scales. It is the most elevated of any of the lesions, and has been so from the beginning. It appeared four months ago, suddenly, in one night, and has increased in size but little since first observed. It has always been scaly, more so than any of the other patches; they are of a dirty-yellowish color, and are cast off daily.

Such was the previous history, and the condition of the patient when she came under observation. She had followed the course of the disease closely, and had noted every symptom from day to day. She had never submitted to any medical treatment, for the reason, as she expressed it, that she had not met with any one who seemed familiar with the nature of the disease; moreover, as the process had made such slow progress and gave rise to no pain, nor indeed to any marked subjective symptoms, she felt disinclined to interfere. Latterly, however, such rapid and unlooked-for developments had occurred that she became alarmed. After a careful examination I was free to confess that the disease was altogether new to me. I advised no treatment until further observation and microscopical study had established its nature.

*Oct. 26.*—The patient to-day shows a new lesion situated on the border of the left mamma near the axilla. It made its appearance last night. I examined this region yesterday, when there was no sign of any disease. Even when she retired there was nothing to be seen. Upon awaking in the morning it was present, and was then of the same size and color and had the same general features as now. It is the size and shape of an olive; remarkably circumscribed; slightly raised, so that its outline can be felt in passing the hand over it; possesses a somewhat harsh surface; and is of a dull-pinkish color. It can be readily taken up between the fingers, is quite soft and supple, and does not feel very different from the surrounding healthy skin. Feeling it with the eyes closed one is surprised to note how slightly the skin differs to the touch from normal integument. It is not inflammatory in the ordinary use of this word, there being neither heat, itching, nor pain. The patient indeed was not aware of its existence until when performing her toilet in the morning she happened to see it. It does not disappear in the least degree nor change color under pressure. The view of its being

hemorrhagic does not suggest itself. In appearance it may be compared to a superficially-seated vascular nævus without perceptibly-enlarged vessels. It bears some resemblance also to a circumscribed patch of squamous eczema.

*Oct. 27.*—The patient experiences for the first time a slight burning sensation in the patch upon the forehead. The lesion on the inner surface of the arm has since yesterday increased in size about a line uniformly around its entire circumference. The enlargement is shown by the fact that the recent growth is of a shade brighter red than the old, the line of difference being quite plain. The growth occurred through the night. The tubercles in the centre of this patch have not undergone any change either as to size or color.

*Oct. 28.*—The small, diffused, reddish lesions in the cheeks are paler and fainter in outline. The patch in the left groin is also paler, less prominent, softer, and is inclining to clear in the centre. A new patch, similar to that which exists on the left mamma, made its appearance last night on the inner surface of the left thigh near the perineum. It is the size and shape of a small pecan-nut; raised a quarter of an inch above the level of the surrounding skin; of an uniform dull pink color; and is freely movable with the healthy tissues and can be drawn out into any shape, showing that it is superficially seated.

*Nov. 4.*—The changes this week have not been so remarkable as during the previous week. The large tumor on the right side of the forehead just above the upper eyelid has increased perceptibly in size and is of harder consistence. On its upper border it is now continuous with the flat lesions of the scalp. Two of the smaller tubercles of the forehead have likewise enlarged. The recent patch on the left breast, near axilla, is more raised and of a deeper red than a week ago, but it has not increased in size. To-day I punctured with a fine-bladed knife three of the most prominent lesions of the forehead, the operation in each instance being followed by a few drops only of dark, thick blood, which under the microscope showed red corpuscles in profusion, and a limited number of white corpuscles, but no other cell elements. The fluid dried very rapidly upon the slide.

During the past three days there has been for the first time considerable itching about the forehead. The tumor in the centre of the back has undergone marked diminution in size within the week, being now less than half its former size: it is also paler and more scaly. It seems to be drying up or shrivelling, in the manner that a wart might disappear. There has been no treatment of any kind up to the present date.

The following was to-day ordered: R.—Sodii Sulphatis, 3iss; Potass. Sulphatis, 3ii; Potass. Bicarb., 3iii; Lithii Carb., 5ss. Sig. Half-teaspoonful with a gobletful of water before breakfast.

*Nov. 11.*—The patch upon the forehead as a whole is softer, flatter, and paler than last week. It looks as though it were about to undergo gradual absorption. Within the week there has appeared

a distinct, deep crease or furrow through the centre of the tumor over the right eye, which runs vertically and at a right angle to the eyebrow. It is manifest that these furrows (which have been referred to as existing elsewhere), which form upon the tumors as well as between them, constitute a striking feature of the disease. From a study of the one recently formed it is obvious that they cannot be regarded as exaggerated natural lines. They are formations peculiar to the process.

Night before last the patient was awakened from a sound sleep by pain in the large tumor over the right eye. At first there was a distinct sensation as of expansion and contraction taking place through the growth. She describes it as though many threads were drawn rapidly to and fro through it,—like the opening and closing of the mouth of a sack by means of draw-strings. It lasted an hour and subsided gradually, to be followed by a sharp pricking sensation, as though needles were being forced through the tumor. This continued for a few minutes only, and was succeeded by intense itching. During the morning (four or five hours later) she scratched the skin open at one point, when about a dozen drops of blood oozed forth. This was the first occasion of any bleeding, whether here or elsewhere. With the cessation of the bleeding the itching abated. The evening before these symptoms manifested themselves the tumor appeared to be in its usual condition, and did not exhibit any sign of turgescence; it was indeed, as has been stated, even considerably softer than a week previous. The other lesions upon the forehead or elsewhere did not in any way sympathize with the changes just noted.

*Nov. 20.*—The recent small, flat, indistinct lesions which appeared here and there over the face a week or ten days since have completely vanished within the past few days.

*Dec. 1.*—During the past three weeks a marked change has taken place in the tumor over the right eye; it is less prominent, smaller, softer, and paler, and is undoubtedly undergoing absorption. A rounded, hazel-nut sized, firm, pinkish tumor appeared last night on mastoid region behind the right ear. The patient was not aware of its presence until I called her attention to it. It is of the same character as those which have from time to time occupied the scalp, and which have been already referred to in detail. The treatment was ordered to be discontinued.

*Dec. 11.*—The large tumor over right eye is still decreasing in size, and is flattening materially. It has, moreover, cleared in the centre, and shows here a spot of almost normal skin. A new lesion is to-day appearing behind left ear; it is identical with that which was noted three weeks since behind right ear.

*Dec. 27.*—A small, circular, firm, raised, reddish lesion, accompanied with soreness and heat, was observed this morning on the anterior surface of the right thigh, to the left of and close to the large lesion already described.

*Dec. 28.*—Hard, irregular, lumpy elevations, the size of split

peas, smooth, glistening, and pale-violaceous in color, have since yesterday appeared behind both ears on the border of the scalp. On the left side they consist of a chain-like series of small lesions which extend down into the neck. Behind the right ear they form a cluster and incline to coalesce. They are itchy.

*Dec. 31.*—The single tumor behind the right ear has doubled in size within the past fortnight, and has flattened. It has, moreover, become distinctly divided or lobulated, consisting now of three irregularly-shaped parts separated by deep furrows identical with those described in connection with the forehead lesions. The circular patch on the anterior surface of the right thigh has increased in size, and has become sensitive, and is even painful when touched. It is the seat of distinct shooting pains, which extend up and down the limb.

The following external treatment was ordered: Equal parts of lead and mercurial plaster, to be applied, spread on a cloth, to the large tumor over the right eye; and calomel ointment, one drachm to the ounce, to be rubbed twice daily into the lesion on the left breast and into one of the flat scalp lesions.

*Jan. 3, 1878.*—Patient observed this morning, on combing her hair, three flat, firm elevations, the size of dimes, situated on the right side of head above the ear; they were dull-pink in color, were covered with minute, thin, whitish scales, and were intensely itchy.

*Jan. 7.*—This morning a small, finger-nail sized, circular, firm, slightly-elevated, pinkish lesion was noted on the left breast. It came through the night, and is unaccompanied by any subjective symptom. Four small, raised, smooth, violaceous lesions, situated closely together, have come on the right thigh near the large circular patch. This latter lesion is growing markedly from week to week, being now two and one-half inches in diameter, and still remains raised and covered with a dry crusted scale. It is, however, no longer the seat of pain, nor is it even sensitive, as was formerly the case.

*Jan. 10.*—The mercurial plaster caused excoriation on the fourth day. The calomel ointment likewise proved irritating. One minim of liquor potassii arsenitis, twice daily, was ordered. Upon rising this morning the patient observed two new lesions on abdomen.

*Jan. 22.*—Patient is under the toxic influence of arsenic, and has been in this condition for several days. The disease is everywhere the seat of considerable irritation, as shown by increase in the size of the lesions, great heat, and intense itching. Arsenic discontinued, and a carbolic acid lotion ordered.

*Jan. 29.*—The lesions upon the forehead have of late been growing, and within the week have changed their character. The epidermis has macerated, and has been scratched off in places, especially from the larger tumors, leaving excoriated, oozing surfaces upon which a dark-brown thin crust quickly forms. Half-minim doses of liq. pot. ars. were again ordered.

*March 1.*—The changes during the past month have not been so numerous nor so decided as formerly. New lesions have appeared and old ones have disappeared, leaving more or less marked dirty-yellowish discolorations, while others have remained in *statu quo*. A few of the more remarkable changes may be specially referred to. The forehead lesions have softened. Those behind the ears are being absorbed and are rapidly disappearing. One of the scalp tumors has enlarged, and now stands raised a full half-inch above the level of the healthy scalp, while another immediately alongside of this one has softened and flattened. A rounded tumor is growing rapidly in the centre of left cheek. On the lesion which occupies the flexor surface of the right arm near the axilla the following has taken place: Four weeks ago the outline of the patch broke at a given point on its inner border and began to clear away. This patch is now the same size as formerly, but in the place of being a solid mass of disease shows a strip of healthy skin, a half-inch in width, which runs in the form of a "cul-de-sac" from a point in the circumference to the centre of the patch. The skin here is restored to health and is sharply defined against the disease. Just beyond this "cul-de-sac" of sound skin, in the centre of the patch, there are several hard, smooth, violaceous, nipple-shaped elevations or tubercles, of the same character as those on the forehead and in the groin. No subjective symptoms are noted. Several quite large abdominal lesions have entirely disappeared, without leaving scars or even pigmentation. Arsenic in half-minim doses soon again produced constitutional and cutaneous disturbance.

*March 6.*—A fortnight since the large tumor on the scalp was accidentally struck with violence. It became painful and soon suppurated, discharging about a fluidrachm of pus and blood, after which the wound healed kindly. The tumor in the left popliteal space has grown considerably of late; it is irregularly rounded, with the central mass elongated, running parallel with the flexure, and thrown up into several thick, fleshy, rounded folds or welts with corresponding marked deep furrows. The patch in the left groin has increased to the size of a small hand and is irregularly elongate in shape; it is broken up, and consists of small and large patches of disease in the form of flat and raised, diffused and circumscribed tumors in all stages of evolution. Here and there are islands of healthy skin, where former lesions have existed and have since been absorbed, while the centre of the patch is quite clear and shows normal skin. None of the lesions, upon the surface generally, are itching so much as a month ago.

The disease has up to the present time in no way affected the general health of the patient; the appetite is good, and the various functions continue in order. Urine normal. No involvement of lymphatics.

*April 9.*—A week ago five grains of iodide of sodium, thrice daily, was prescribed. The patient states that on the second day she experienced an unfavorable change, and that she felt uncom-

fortably warm and excited, and had a hot, dry skin. These symptoms increased from day to day. The disease, moreover, became everywhere redder, the lesions enlarging markedly and itching intensely. Within the last two or three days many new lesions, of both the flat and elevated variety, have appeared upon various regions of the body. Upon examination I find the disease to be in a manifestly active state, all the symptoms being aggravated. The remedy was discontinued, and acetate of potassium substituted.

*May 1.*—The general condition for the past month has not been so favorable. She has experienced a weary state of the body, together with frequent flushing and heat of skin. Ten days ago an attack of diffuse urticaria made its appearance and continued five days. The large tumor of the scalp is flatter, softer, and possesses a sense of fluctuation. The older formations on the forehead are likewise flatter and softer, and have recently become abraded and crusted with a thin yellowish coating, the result of a slight oozing which has quite lately appeared accompanied with intense itching. The kidney-shaped lesion on the side of the forehead has become much smaller, flatter, softer, and paler, and is undergoing absorption; it is less than half its former size. The tumor at the root of the nose has grown rapidly, and is now the size of a half-cherry, and is circumscribed, firm, smooth, glossy, and of a bright raspberry red color, and is unaccompanied by subjective symptoms of any kind. The growth in the left cheek (which started, it will be remembered, three months ago) has increased in size until now it is as large as a large cherry; it has been repeatedly punctured with a fine knife-blade by the patient, but the procedure rather aggravated the process. An alkaline saline aperient has been ordered in place of the acetate of potash. Locally, a carbolic acid ointment affords relief to the excessive itching.

*June 1.*—Three weeks ago an attack of general discrete and confluent urticaria again made its appearance, similar in its course to the preceding manifestation. It continued five days, during which period the patient was feverish, and experienced general malaise. The patches of the disease, however, were not invaded.

*June 14.*—Another attack of urticaria has occurred. As before, there was no gastric derangement, but the eruption was marked by accompanying depression of spirits and by pain in the head and back. The lesions were unusually numerous, every portion of the surface, even the patches of disease, being invaded; they remained, as before, five days, disappearing gradually.

The following marked changes, in addition to those which have been referred to, have occurred during the past three months. The patch under the right arm has increased but little in size, but its border is considerably raised, and exists in the form of a ridge, with here and there lumpy, tubercular elevations from a quarter to a half-inch in height. The whole patch, moreover, has become thickened and indurated, and at the same time smoother and in some places even glossy. The color has become more violaceous.

Itching is marked, and at times is even intense. The palm-sized patch under the right breast has doubled its area, and here and there shows ridges and tubercular, lumpy formations identical with those on the arm just described; one particularly conspicuous tumor, the size of a half-walnut, arises from the border of this patch; it is excoriated, and oozes bloody serum, and itches violently. This tumor is of two months' duration, having made its appearance during the period that the iodide of sodium was taken. The patch on the right thigh has grown to double its former size (being now circular, and four inches in diameter), and has at the same time cleared away in the centre to the extent of a silver dollar, the skin here being quite normal.

The large scalp tumor, which has been softening for some time past, began to discharge some three weeks ago, and has since been discharging about a fluidrachm daily of a puriform fluid.

Fluid extract of ergot, in half-fluidrachm doses, to be increased, thrice daily, was ordered.

*June 25.*—The numerous flat purplish lesions on the sides of the thorax, extending over the ribs and as far down as the thighs, disappeared rapidly as the urticaria vanished. They faded with remarkable rapidity, so that within a week there was scarcely a trace of their former existence to be found beyond a general dusky-yellowish pigmentation.

The lesions on the forehead are much softer, and bleed easily and copiously once or oftener in the day. The large tumor on the left cheek, which has been growing steadily for the last three months, for the first time shows signs of softening, and displays a slight depression in the form of a furrow in its centre, such as has been noted in connection with other lesions. The tumor measures in circumference at its base three and six-eighths inches, and around its greatest circumference five inches. The scalp tumors have lately become excoriated, and are now discharging a full half-ounce of puriform fluid in the course of the twenty-four hours; they are materially smaller, softer, and flatter. Their surfaces are either excoriated or are covered with a thin or thick brownish crust, which can be readily removed (very often entire) in the form of a concave shell.

The itching which has been such a prominent symptom of late has everywhere entirely ceased within the past week.

*July 1.*—The large tumor on the left cheek so annoys the patient that she desires its removal at any risk. In consultation with Dr. Maury, the base of the growth was transfixed by two stout pins inserted at right angles to each other, and strangulated by a silk ligature. The surface of the tumor oozed minute drops of bloody serum, but showed no disposition to rupture.

*July 2.*—The tumor is coal black, and the seat of throbbing pain; oozing still continues.

*July 4.*—The pain has subsided. The growth being offensive, it was ablated close to the base. There was considerable hemorrhage

which sprang from two arterioles. Upon the knife entering the formation resistance was encountered, the structure proving to be firm and solid. The cut surface presented a homogeneous yellowish-gray color. No blood or serum oozed from the tumor after removal. It weighed one ounce.

*July 5.*—The swelling about the upper part of the cheek continues and the part looks as though attacked with ordinary erysipelas of a mild form, but the eyelids are not involved. Suppuration is taking place freely.

*July 7.*—To-day the wound looks healthier and vastly improved. A hard base still remains in the centre of the wound, which it will be necessary to destroy. The general condition and spirits of the patient are excellent.

*July 11.*—The hard base referred to was cauterized with caustic potash and quite thoroughly destroyed.

*July 20.*—The wound granulates slowly. A trace of the disease in the form of a hard, pea-sized mass deep in the centre of the wound was to-day removed with caustic. The operation, unlike the previous one, gave but little pain.

*Aug. 27.*—The wound granulated favorably, and closed entirely three weeks since, leaving a quite insignificant scar. Four weeks ago a new tumor made its appearance on the inside of the middle of the right thigh, which in a fortnight grew to the size of a small hazel-nut. It was excised; was followed by scarcely any hemorrhage, the wound healing kindly and rapidly. Three weeks ago a lesion appeared over right scapula, which has within a fortnight grown to the size and shape of a small horse-chestnut. The tumor at the root of the nose has lately attained its full development as indicated by the central furrowed or V-shaped depression, and by a disposition to soften; it is rounded, stands out boldly an inch and a half from its base, and has the exact form of a young mushroom before it has begun to expand. This tumor is identical in size, shape, and in every other respect with that which occupied the left cheek.

The changes which have taken place during the past two months with other lesions, excepting those to which special reference will presently be made, have not been remarkable. Many new flat and more or less raised ones have from time to time appeared, and in many instances have completely disappeared; many of the older ones remain in *statu quo*; others have coalesced; some have broken up and have cleared away in their centres or on their borders; while still others have been entirely absorbed and have vanished. The skin therefore presents tumors, flat patches, and pigmentary discolorations in all stages of evolution, there remaining scarcely a square inch of skin upon the trunk that has not at one time or another been the seat of disease.

I desire to refer in particular to three lesions which have existed for some time, and which on account of their size and other peculiarities have been more than once mentioned; they show phases of

the natural course of the disease. The large, horse-chestnut sized tumor on the temporal region, which manifested itself about a year ago, and which eight months since began to soften and decrease in size, has latterly been completely absorbed, leaving the skin normal with the exception of a slight, yellowish, fatty degeneration, looking not unlike small areas of xanthoma here and there. The large tumor of the scalp has in like manner been absorbed, and is now nearly upon a level with the healthy skin. The same fatty, xanthomatous deposit is here observed in the skin as upon the remains of the forehead lesion just referred to.

The lesion in the left popliteal space which on March 6 was described as being "irregularly rounded with the central portion elongated and running parallel with the flexure, and thrown up into several thick, fleshy, rounded folds or welts with corresponding marked deep furrows," has increased enormously in proportions. It now includes the whole of the popliteal space, being quite four inches in diameter, is irregularly rounded, and broken up into areas of disease and of comparatively normal skin (where former lesions existed which have undergone absorption); and consists mainly of an irregularly-shaped, firm, projecting, distinctly and deeply furrowed, lobulated, warty, fleshy, fungoid, dark-reddish mass, secreting a viscid fluid which dries into crusts. It stands out from the patch an inch and a half, and is proportionately bulky. Around its base here and there are a half-dozen variously-sized, violaceous tubercles similar to those encountered on other parts of the body.\*

#### MICROSCOPICAL EXAMINATION.

Some months since a piece of tissue about three lines square was excised from the large tumor of the scalp. It was taken from the periphery and included a small portion of healthy skin. It was removed with a knife, and was immediately placed upon the disk of

\* Since the case was presented to the Association the large, horse-chestnut sized tumor at the root of the nose has been excised. There was considerable hemorrhage which was only arrested by the use of ligatures. Two quite large arteries were found on either side of the base of the growth. The edges of the wound were brought together by pins and interrupted suture. The wound suppurred freely and healed remarkably rapidly and favorably. Within a fortnight it closed, there remaining but a faint reddish ridge to mark its site. At present writing even this has disappeared; there is no contraction of the tissues, nor is there the least disfigurement resulting from the operation. The rapidity with which the wound healed is worthy of special remark, more particularly as the tumor was not isolated but adjoined and was merged with the original mass of disease, the incision, therefore, on one side being through diseased tissue. The diseased surface showed readiness to unite with the opposite side of the wound composed of healthy skin, and as stated granulated most favorably to complete recovery.

In regard to the treatment, I would say that at one time it was thought benefit was being derived from the use of ergot, but subsequent experience showed this to be an unwarrantable conclusion. It was in time abandoned as being of no value. No internal remedy used has appeared to exert any influence in controlling the disease. Excision of the circumscribed tumors can, I think, be safely recommended.

a freezing microtome and frozen. The sections were cut by my friend Dr. Morris Longstreth, to whom I am also indebted for the accurate drawings. They were at once stained with carmine, and were examined in a weak saline solution.

Under a low power the whole section is seen to be well infiltrated with a cellular formation. With a power of three hundred and fifty, the following condition is noted: the horny layer of the epidermis is thin but preserved and distinctly defined; the rete mucosum is well developed and clearly marked; the papillary layer is quite sharply defined against the rete; some of the papillæ are materially shorter and broader than normal, while in some places they are so flattened out as to be almost obliterated; the whole of the corium, from the apices of the papillæ to the subcutaneous connective tissue, and even as far down as the specimen extends, is almost solidly infiltrated with a new growth composed of small, well-defined, rounded, indifferent cells; the infiltration is remarkably dense, taking complete possession of the normal tissues; it exists in the papillary layer as high up as the summits of the papillæ, and in great quantity throughout the whole corium; the cells are more numerous and closely packed in the lower strata of the corium than in the papillary layer. While they may be said to be disseminated, showing no marked disposition to arrange themselves in any definite arrangement, they are, in some localities, noted to be more abundant, being here and there heaped together. Along and parallel to the walls of the follicles, and occasionally in other places, but to a less extent, they are arranged in irregularly-formed rows. But the arrangement is not striking, and cannot be compared with that found in the cheek tumor, to be presently described. The walls of the follicles are packed with the new growth, as are also the parts of cut glandular structure that here and there come into view. Cut blood-vessels are encountered in the upper as well as in the lower strata of the section, some of them being of unusually large size. In the walls of these vessels are imbedded in profusion elongated and round, new and old, cells.

The cells are, as a rule, not distinctly nucleated; some have punctate, quite undefined nuclei, while others show a larger, round nucleus; others are without nuclei, being composed simply of a more or less granular substance. None appear to have more than one nucleus. The cells are variously sized, sharply-defined, compact cells, similar to those found in lupus and scrofuloderma. They are variously shaped; some are rounded and oval, while not a few are elongated and even spindle-shaped. They are imbedded loosely or securely in a connective-tissue stroma, which is for the most part faint and delicate in structure. In many places the cells are so numerous and so closely packed that scarcely a vestige of the corium remains. (See drawing Fig. 1.) But few marked connective-tissue bundles and elastic fibres are present.

A large number of sections were carefully examined by Dr. Longstreth and myself, all of them yielding the same result. The disease





was quite uniformly distributed throughout the entire excised fragment of tissue.

Since the above examination, Dr. Longstreth and myself have quite recently resumed microscopical study upon a large tumor which was excised from the cheek, and have obtained results so different from those just described as having been found in the scalp tumor as to be equally worthy of record.

A section a quarter of an inch square was cut from the side of the tumor in such a manner as to include sufficient disease, and a portion of sound skin about the border. It was, as in the previous examination, frozen upon a microtome, the sections being cut vertically from the periphery towards the centre. They were stained with carmine, and examined in a fifty per cent. glycerine solution.

The horny layer of the epidermis is remarkably thin, so thin in some places as to be scarcely recognizable with a low power. The rete is only fairly developed. The papillary layer is flattened out to such an extent that for the most part indications only of the papillæ remain; while the follicles are shorter and broader than normal, or they are contracted, their walls being squeezed together. As in the scalp tumor, the whole structure from the papillæ to the lower strata of the subcutaneous connective tissue consists of a profuse multiform cell infiltration, contained in a delicate network of connective tissue, arranged in a peculiar manner. (See drawing Fig. 2.) It will be remembered that the cells in the sections of the scalp tumor showed no marked peculiarity of disposition. Here, the arrangement of the new growth is striking, being in the form of numerous, distinct, long, narrow, similarly-sized and shaped, trabeculæ or columns situated about equidistant from one another. They incline to run vertically, but in this respect are subject to variation, some of them running at angles to one another, while others meet and cross at right angles, thus forming a sort of basket-pattern arrangement. Many of them converge and meet at an angle as represented by the shape of the letter V, the apex, however, pointing upwards instead of downwards towards the periphery of the tumor. Between these trabeculæ there are apparently open, translucent channels or spaces, but which on close inspection are noted to contain very faint, delicately-formed, gelatinous-looking connective tissue, recognizable only with a high power. These apparent spaces everywhere accompany the trabeculæ, and are about as long and as broad as the latter, and are quite as distinctly defined, the whole structure consisting of alternate trabeculæ and spaces. While this arrangement, as just stated, prevails throughout the bulk of the section, it becomes less striking towards the papillary layer, and again, as the deeper strata are approached, where the cells take on the form of a diffuse infiltration, as in the case of the scalp tumor. Beneath the rete the corium in many localities is still preserved, the cells being by no means so abundant as in the deeper portions. The cells constituting the trabeculæ are closely crowded together, and are in many places

even fused or united, constituting a quite solid column or mass of formed material.

Partially adherent as well as great numbers of free cells are also seen here and there, in aggregations or disseminated, throughout the field. The cells vary considerably in size, more so than in the sections of the scalp tumor, and are, moreover, decidedly larger. They likewise vary in shape, being round, rounded, ovalish, and even spindle-shaped. Their contents are for the most part non-granular; distinct nuclei, however, are only occasionally encountered. The picture thus presented in this part of the tumor is suggestive of fibro-sarcoma.

A vertical section taken from the centre of the base of the tumor shows a structure quite different from that of the upper part or periphery of the growth. (See drawing Fig. 3.) It exhibits very beautifully the earliest stage of the process. The tissue is materially looser, and is made up of subcutaneous connective tissue, abundance of elastic tissue in the form of single fibres and variously-sized bundles of fibres, fat-globules, blood-vessels, and here and there striped muscular fibre. The whole structure is infiltrated with cells which are either disseminated or arranged in variously-sized, irregularly-formed, loose or dense aggregations. The cells differ from those found in the upper portion of the growth in being more granular, more succulent, and much larger. They vary greatly in size, some being more than twice as large as others. They resemble simple granulation cells which have just made their escape from the vessels. They are numerous, being found here and there, singly or in aggregations, in almost every portion of the section, but they are by no means so abundant as in the upper strata of the tumor. It is manifest that in this specimen we see the cell in its earliest or most recent form, and from a careful study of its features, it is found to differ but little, if at all, from the corpuscle which characterizes simple inflammation.

The three specimens show plainly the several pathological stages of the disease, and particularly the character of the cell as it exists in the earliest and in the oldest portions of the growth. The difference between the large, granular, irregularly-formed, succulent cell in the base, and the small, hard, persistent, rounded cell in the periphery of the tumor is certainly quite striking. From the results thus obtained I think we are warranted in regarding the growth as being in its early career simple inflammatory, as being, in fact, a kind of granuloma; while later (after distinct, firm, fleshy tumors have formed) it assumes such a state as to suggest the term fibro-sarcoma.

My friend, Dr. C. Heitzmann, of New York, who examined the patient at the meeting of the Association, has taken interest in the case and has recently been kind enough to make a microscopical examination of sections of the large cheek tumor. In a letter just received from him he reports:

"The sections of the tumor exhibit as follows: The epidermal

layers thinned, otherwise unchanged; the papillary layer mostly flattened, the papillæ being shallow or not present at all; the derma partly built up of bundles of fibrous connective tissue, demonstrable both in longitudinal and transverse sections, partly infiltrated with mainly globular elements closely packed together, producing clusters of varying diameters, or they are arranged in longitudinal strings, according to the former strings of the fibrous connective tissue. These run a course parallel to the outer surface in the former papillary layer and obliquely through the main mass of the derma.

"The elements are of the size of lymph-corpuscles, compact, shining, or coarsely granular, devoid of nuclei in their smallest representatives, and vary from this size up to that of human colorless blood-corpuscles, or even surpass the size of the latter. The larger elements are coarsely granular, and exhibit nuclei in varying number.

"There are transitions from the fibrous connective tissue into the protoplasmic condition of this tissue, and from this into the newly-formed elements of the tumor. Nerve-fibres also demonstrate a transition into the morbid elements, and so do striped muscle-fibres in the lower portions of the tumor.

"The subcutaneous tissue is in some places crowded with the above described elements, and here transitions are traceable from fat-tissue into that of the tumor. Numerous blood-vessels, of capillary nature, in their early stages of development, traverse the tumor everywhere.

"Some hair-follicles, being rid of their hairs, demonstrate a transformation of both the connective-tissue part and the outer root-sheath into elements of the above description; such changes are also seen on the epithelia of some sebaceous glands.

"From this description it is evident that the new-formation is not due to an inflammatory process, but rather to a lively new-growth of elements, which bear the character of *sarcoma*. As a large number of fibrous connective-tissue bundles has formed, before a transformation of the latter into sarcomatous elements has taken place, the tumor deserves the designation *fibro-sarcoma*.

"Tumors of this kind are little, if at all, malignant in their early development, but rather prone to recur after extirpation, hence the old-fashioned term, recurrent fibroma. They are not rare in the derma and the subcutaneous tissue. After growing for years without injuring the patient, they lastly often assume properties deleterious to the patient's health, therefore turning into decidedly malignant tumors. My impression is that, owing to the strong constitution of the subject, as evidenced by the amount of living matter in the sarcomatous elements, the result will sooner or later be deleterious for your patient."

I refrain from making any comment upon Dr. Heitzmann's report, but I regret that I was unable to furnish him with sections taken from other growths representing an earlier stage of the disease,—decidedly more inflammatory in character. There are many points

of interest in the pathology to be considered, so many, indeed, that in the light of one or two cases it is scarcely prudent to arrive at a definite conclusion as to its precise nature. For the present, therefore, I forbear proposing a more specific name for the disease than that which I have bestowed.

#### REMARKS.

I have given the full notes of the case for the reason that the disease has, up to the present time, never been described with the detail which it deserves. It is, as I shall presently show, an almost unknown form of skin disease, but two cases appearing in literature. It is, moreover, a grave and at the same time a very remarkable manifestation, in all respects worthy of a complete record. I may here remark that the observations noted are particularly valuable, from the circumstance that the patient is an unusually intelligent and accurate observer, whose statements I believe to be entirely reliable. The account of the disease, it will be remembered, extends over two years, half of which time the case was under almost daily notice, a period sufficiently long to enable the process to be fully studied. The disease has from the beginning been a most singular one, the development and course of the lesions being quite at variance with what we know of other kindred affections. The variety of lesions; the numerous and remarkable changes that have from time to time taken place; the sudden appearance and the rapid and often unexpected disappearance of many of the lesions; the capricious invasion, cessation, and recurrence, as well as other peculiarities of the subjective symptoms; and the singularly arbitrary course of the process, are all points irreconcilable with the nature of the disease as shown by the microscope.

Inasmuch as the account of the disease which I have given is a lengthy one, and mainly in the form of notes extending over a long period, and for this reason difficult to grasp, I shall endeavor to present a succinct description of its chief features. It may be described as being characterized by several kinds of lesions, which may occur simultaneously or consecutively, in the form of more or less flat patches, or of distinctly raised tumors or fungoid formations. The flat patches vary in size from a finger-nail to the palm of the hand, and are either sharply circumscribed or diffused, oval, round, or irregularly rounded in shape, and either on a level with the surrounding healthy skin or elevated from a half line to several lines above it. They have a smooth and glossy, or a dry, harsh, chapped, more or less scaly surface, with usually well-marked lines, or even furrows; or they are excoriated and crusted. They are superficially seated, thin, supple, and can be readily pinched up between the fingers; or they are deep seated, thick, and fleshy. The prevailing color is a dull-rose or violaceous-red, taking on as the lesions undergo involution varied, yellow, salmon-colored, dirty-reddish tints, due to pigmentation.

The tumors are round or ovalish, circumscribed, tubercular or nodular, or fungoid in character, of a light or dark raspberry-red or violaceous color, varying in size from a split pea to an egg. They are soft, firm, or solid, and when fully developed are here and there more or less distinctly furrowed and lobulated and depressed in their centre. They have a smooth and glossy surface, or they are excoriated and ooze a thin, serous, bloody discharge, or a thick puriform fluid, which dries into dark yellowish or brownish crusts.

The lesions show no disposition to symmetry. All regions are liable to its invasion, the face being particularly involved in the present case. The subjective symptoms, consisting chiefly of itching, are variable, and by no means constant. The course of the disease is likewise extremely uncertain. It is essentially chronic. The lesions follow no regularity or order of development, flat patches and tumors not infrequently appearing simultaneously side by side, while tumors often develop from previously flat patches. They make their appearance either suddenly, often most insidiously, and at times within a few hours, with or without itching; or gradually, in the course of weeks or months, with or without subjective symptoms. Some pursue a rapid, others a very slow and at times capricious course. Having attained a definite size, they, as a rule, soften, diminish in volume, and undergo sooner or later spontaneous involution, without marked pigmentation and without scar. The process up to the present time has been of a benignant nature, but I should be cautious in giving a prognosis.

The microscope at the present period shows the disease to be a peculiar inflammatory new growth, consisting of a profuse disseminated infiltration of small round cells, having their seat in the corium and subcutaneous connective tissue. What further developments or changes in the nature of the process will in future take place remains to be seen.

The disease is, without question, a very rare one. I have never before encountered it. Cases of "fungoid disease of the skin," as they are loosely designated, while they are quite rare are yet from time to time met with, and have always occupied a certain (more or less obscure) place in literature. With few exceptions, however, they are so vaguely reported as to convey to the reader no conception of the disease; or they are upon examination found to be nothing more than vegetating or papillomatous, exuberant manifestations of some well-known pathological process, as, for example, of syphilis. Reports of such cases, unless most accurately and minutely recorded, are of no value to science nor to literature. Some years since Köbner\* collected and reported five obscure cases of fungoid disease of the skin that had been observed in the wards of the Hôpital St. Louis, Paris. He reviews the subject in his paper, and comes to the conclusion that until our information as to the nature of these uncommon manifestations is more definite, all such cases had best

\* Klinische und experimentelle Mittheilungen aus der Dermatologie und Syphilidologie, Erlangen, 1864, p. 37.

be designated under the general title of "multiple, fungoid, papillomatous tumors of the skin," a term which he proposes. Two of these five cases were under the care of Hardy; two under the care of Bazin, who himself reports one of them in his treatise on diseases of the skin\* with the name of "mycosis fungoïde;" while the fifth case had been noted some time previously by Alibert, and is likewise recorded in his work on diseases of the skin.

I have read with care the reports of these cases, and while several of them possess certain symptoms in common with the case I have described, I fail to recognize that they represent the disease under consideration. In reviewing the literature of the subject, it also occurred to me that the affection figured in Dr. Fox's work on diseases of the skin,† and called by him a case of "fibroma fungoides," might be a phase of the disease we are considering, but as we are told that the woman "appeared to have been suffering from syphilis," it must be excluded. Dr. Fox speaks of "fibroma fungoides" as a variety of fibroma differing from fibroma molluscum in its "tendency to ulcerate, to rapid growth, and to vascularity." The disease, however, is very briefly described, and I am unable to establish any relationship between the cases he alludes to and my own.

The only cases on record which manifestly represent the same disease as that under consideration are reported by Hebra. He first met with the disease in 1872, a case having presented itself at the department for skin diseases of the Vienna General Hospital, a short account of which was given in the annual report of that hospital for 1873, under the diagnosis "Neoplasma," it being there stated that the disease was a new one, and that for the time being no other name would be given it.‡ Later, in 1875, the report of this case was republished by Hans Hebra, in the *Vierteljahresschrift für Dermatologie und Syphilis*,§ under the title "Ein seltsamer Krankheitsfall." The title selected was an unfortunate one, for the case did not attract the attention due so important a disease. The bare history was given, and this very briefly. Quite recently Geber|| has again brought forward this case, with additional notes and with remarks, to which are added a chromolithographic portrait and drawings of microscopical sections of the disease. In 1874, Hebra encountered a second case,¶ designating it as before simply "Neoplasma." These two cases are the only examples of the disease on record that I am aware of.

\* *Leçons sur les affections cutanées artificielles et sur la Lèpre, les Diathèses, etc.*, Paris, 1862, p. 375.

† Second American from third London edition, New York, 1873, p. 352.

‡ *Ärztlicher Bericht des K. K. Allg. Krankenhauses zu Wien, vom Jahre 1873. Wien, 1874.*

§ *Zweiter Jahrgang, erstes heft, Wien, 1875.*

|| *Deutsches Archiv für Klinische Medicin, xxi. Bandes, ii. and iii. Heft, Leipzig, März, 1878.*

¶ *Ärztlicher Bericht des K. K. Allg. Krankenhauses zu Wien, vom Jahre 1874. Wien, 1875.*

The first case, of which (thanks to Professor Geber) we have an excellent chromolithograph, was that of a man, Stephen Ruisz by name, an Austrian, aged 47, and a tailor by occupation. I shall avail myself of Geber's description of the case, inasmuch as it is fuller than that given by Hebra.

The disease began two years before, without apparent cause, accompanied with violent itching. At the time of the first appearance of the eruption the patient was feeling generally unwell. Up to that date he had always been healthy. He had never had syphilis. The first manifestations upon the skin were in the form of aggregated, small vesicles upon the face, which owing to the itching were scratched, whereupon they spread. From the face the eruption subsequently extended over the neck and chest, and backwards over the back of the neck and back, and so by degrees over the whole body. Certain patches are said to have undergone complete involution, and, on the other hand, new lesions to have appeared from time to time on unaffected regions; so that within the last half year a noticeable increase of the disease had taken place. The first tumors appeared six months before, on the face, those on the other parts of the body having followed at irregular intervals. The patient discriminated between the several lesions upon the skin, and stated that the tumor-like growths made their appearance upon previously diseased skin, and that other lesions came suddenly and often disappeared.

The patient when he came under observation was in average health and was well nourished. The most recent lesions consisted of scattered pin-head sized papules and pustules seated upon a reddened base and covered with a brownish crust. Where the process was more advanced there were hand-sized and larger, discrete and confluent, vesicular and crusted, or excoriated and moist patches.

Where the disease was evidently undergoing involution, the more or less infiltrated skin was scaly. In such places there was but little disease, the swelling had disappeared, and the dark pigmentation was almost the only remaining symptom of the previous persistent eczema-like eruption. Scattered over the whole body, for the most part on normal skin, but also in the middle or about the circumference of the patches just referred to, there were large and small, some an inch and a half in length, raised to the height of several lines, bright red, firm, fungoid elevations. They were smooth on their surface, and were only occasionally cleft. Pedunculated tumors, varying in size from a hazel-nut to a goose-egg, existed on the neck about the region of the larynx, on the arm and about the folds of the axillæ, and on the thigh below Poupart's ligament. They were somewhat lobulated and furrowed; richly vascular; and had an elastic feel. They were in part deprived of epidermis, and were covered with brownish-yellow crust. The lymphatics were everywhere swollen, especially over the mastoid region, where there also existed a moist eczema.

The disease remained under notice five months, during which

time many changes were observed, consisting mainly in the development of new lesions and in the disappearance of old ones. The course of the disease was similar to that noted in my case. Toward the fifth month of the patient's stay in the hospital fever and uncontrollable diarrhoea set in, followed by erysipelas migrans, which proved fatal. An autopsy was made, but showed nothing abnormal in the internal organs.

The microscopical examination of the tumors is thus given by Geber: Beneath the well-marked and preserved cells of the epidermis there existed a sharply-defined, moderately-developed papillary layer. Owing to the cell infiltration as well as to the increase and swelling of the connective tissue of the papillæ, these bodies were elongated and broadened. The corium below had in the same manner increased in volume. The number of the imbedded cells was relatively large, and their manifold form noticeable. There existed disseminated or aggregated round, roundish, oval or elongated lymphoid cells, with all transitional stages to spindle form. The latter were noticeable through their strongly-granular protoplasm and relatively-large nucleus. The connective tissue showed in places the several stages of its development; the bundles of the same were swollen and oedematous, their borders ill defined, and the fibrillar character scarcely perceptible. Elastic fibres were scanty. Vessels were present in abundance, their volume being upon the average markedly enlarged.

Beneath a relatively well-preserved rete there was found, in the best developed portions of the disease, in the papillæ and throughout the corium, a profuse cell infiltration. As this was viewed more closely, it was observed that the first changes, namely a noticeable increase of round cells, took place in the papillary layer and upper strata of the corium, and particularly along the vessels of the same. As the process intensified, the cells increased, and in such a manner that they not only destroyed the tissues attacked but extended themselves into the subcutaneous connective tissue, where both small and large collections of cells were still to be seen. In general the increase of cells was found to be in inverse proportion to the amount of intercellular tissue; on the periphery, for example, a diminution was scarcely perceptible, while the nearer the centre was approached the more marked it became, so that ultimately the merest trace only of stroma remained. This became plain, more particularly in sections that had been well shaken, in which after the cells had fallen out there appeared variously-sized, formed spaces, surrounded by delicate connective tissue. The cells themselves, as stated, were round, ovalish, and occasionally elongated; as a rule their substance composed of a coarsely-granular protoplasm contained a large nucleus, and the presence of two nuclei and of corresponding nucleoli was not uncommon. About the lower border in the subcutaneous connective tissue a large number of enlarged blood-vessels cut in various directions were seen; near by also well-preserved sweat-gland ducts.

The second case was a merchant of Warsaw, 36 years of age, who had always lived in good circumstances, and had seldom been sick. He was of average size and of frail build, but is said to have been formerly stronger. The disease of the skin had begun a year and a half before, upon the head, and had spread rapidly, but for several months had been in *statu quo*. Upon his admission to the hospital, the scalp, face, thorax, upper extremities, abdomen, and lower extremities as far as the knees, were reddened and covered with quite large scales, presenting the characters of *eczema squamosum*, accompanied with violent itching. Above the umbilicus, reaching around the waist, there were six, variously-sized, from a dollar to the size of a hand, compact, doughy, raised, to the height of three lines and more, excoriated infiltrations, covered with loosened or abraded epidermis. Where this had been destroyed there was a moist surface. These tumors were the seat of no pain, and annoyed the patient merely on account of their size.

The growth pursued a slow course. Through a period of weeks there was scarcely any change. The functions of the body were in no way impaired, and the appetite remained good, but sleep was interfered with, owing to the intolerable itching. The patient was rubbed twice daily with *ol. rusci*, for a period of nearly two months, during which time the itching diminished, but on ceasing the application it returned, though in a milder degree. Two of the tumors were destroyed with caustic potassa. The edges of the wound were clean, but the healing process proved an extremely slow one; the secretion was abundant. The patient was under observation eighty-eight days, during which period the disease manifested but little change. The microscopical examination of excised portions of the tumors, it is stated, afforded no information concerning the nature of the disease, inasmuch as nothing more than an increase of the normal elements of the skin were found (*sic*).

It will, I think, be readily admitted that both of the cases just reviewed present many features in common with our case, and that there can be no question but that the three cases represent the same disease. Hebra's first case, in particular, is indeed identical in almost all of its features with mine, including the history; the irritability of the general integument previous to the development of the disease proper; the evolution and the general character of the lesions; the subjective symptoms; the course of the disease; and lastly, the microscopic appearances of the formation as given by Geber. The points of difference in the clinical history are so insignificant as scarcely to be worthy of special remark. I am quite at a loss to account for the statement of Hebra, Jr., to the effect that in their second case he was unable to discover anything abnormal in the excised piece of skin submitted to the microscope.

In corroboration of the view of the simple inflammatory nature of the process which I have put forth, we have the clinical facts that both arsenic and iodide of potassium seriously aggravated the disease on the several occasions on which they were prescribed, pro-

ducing symptoms identical to such as we should expect from their employment in simple acute inflammatory diseases of the skin, as, for example, in eczema.

In regard to the diagnosis of the disease, I cannot see that any difficulty could possibly arise, for the features are so striking and peculiar that they must impress themselves forcibly upon the observer. The several diseases with which I conceive it might be confounded are the vegetating, hypertrophic or fungoid varieties of syphiloderma, lupus vulgaris, carcinoma, leprosy, and lymphadenoma of the skin ("mycosis fungoïde" of Gillot\*), and with framboësia (yaws).

It seems scarcely necessary after all that has been said to add that these diseases have all been carefully excluded in the present case. The disease is without doubt one *sui generis*.

### URTICARIA PIGMENTOSA.—REPORT OF A CASE.†

BY P. ALBERT MORROW, M.D.,

Physician to the Skin and Venereal Department, New York Dispensary.

I AM induced to give a detailed report of the following case, as it seems to be a well-marked example of an anomalous form of skin disease which has recently attracted considerable attention among dermatologists in London, and the precise nature of which is still a matter of dispute.

The first case which I find recorded was brought before the Clinical Society of London, in December, 1874, by Mr. W. Morant Baker. At the same meeting Dr. Tilbury Fox presented a similar case as an "undescribed eruption," to which he gave the high-sounding title of *Xanthelasmoidæ*. Dr. Barlow exhibited a case in 1877; and finally Dr. Sangster, in April last, exhibited an example of the same eruption, which he termed, provisionally, *Urticaria Pigmentosa*.

My case, some of you may remember, was first brought before the New York Dermatological Society at the October meeting, 1876. I will read from the secretary's report my brief notes of the case as then presented (*ARCHIVES OF DERMATOLOGY*, vol. iii. p. 140).

"The patient, a well-nourished, healthy-looking child, nearly 2 years of age, came under observation some two months previous at the New York Dispensary. The body was covered with an eruption which had existed since the child was 6 months old. The spots varied in size from that of a pea to a ten-cent piece. They were distinctly elevated, and papular or tubercular in character. They covered the face and entire body, but were most abundant on the

\* Étude sur une affection de la peau décrite sous le nom de mycosis fungoïde (lymphadépie cutanée), Paris, 1869.

† Read before the New York Dermatological Society, Dec. 10, 1878.

back and over the flexures of the joints,—a few could be seen on the palms of the hands and soles of the feet; ordinarily they were of a pale-yellowish color, but when the child cried or became excited, they changed to a reddish or bright-scarlet hue.

"The elevations could be plainly felt by the finger passed over the surface. When violently rubbed or scratched, the elevations became more marked and the surface appeared as if nettle-stung. There was an unmistakable urticarial element in the disease, as the mother states that whenever the child's stomach is disordered he has the 'hives'!

"The mother gave the following history: he is the youngest of nine children; none of the others have ever had skin disease. He was vaccinated when four or five months old. Previous to this time he had never had any signs of an eruption, except an occasional attack of the 'hives,' which always subsided in two or three days. A month or two after vaccination, she noticed a few small reddish pimples on his back and chest. Soon the entire body was profusely covered, presenting the same appearance as exhibited now. There has been no retrogression, or fading out of the eruption, at any time since its first appearance."

The child was under my observation for eight or ten months succeeding its exhibition before the Society. The clinical history of the case during that time may be briefly summarized. There was quite an appreciable series of changes in the physical characteristics of the eruption. It was marked by an obvious increase in the number of pigmented spots, and the appearance, successively, of small crops of tubercles or nodulated masses, which were irregularly distributed, more frequently observed on the back, between the shoulders, and around the neck. These masses, which projected several lines above the surface, were not rounded or conical, but irregular in outline, as if formed by an aggregation of small nodules. They varied in size from that of a coffee-grain to that of an almond. When newly formed they were pinkish or bright red, but as they grew older they assumed a pale-yellowish or brownish color. They were firm to the touch, often of a pearly lustre, giving a deceptive indication of fluid. Repeated punctures, however, were never followed by the escape of pus. Some had the appearance of a solid, lardaceous deposit, over which the skin was tensely stretched. They seemed to be capricious, both in their evolution and retrogression. They would develop suddenly, always after an urticarial attack, remain stationary for a variable time, and then undergo a rapid process of involution. I have frequently marked one or more of these protuberances with indelible ink, and on the next visit, a week later, they had entirely disappeared. Repeated observations showed that their average duration was from one to three weeks; sometimes, but rarely, longer.

The treatment may be indicated in a few words. I gave acetate of potash in conjunction with other diuretics, and directed the employment of hot baths once or twice a day. This was followed by a decided improvement in the appearance of the disease, which I

first attributed to the medicine, but which, I was afterwards convinced, was due to the cooler weather. I found that the external temperature had a marked influence on the eruption. During the winter the urticarial attacks are less frequent, the spots fade out partially, and the tubercular masses appear at rare intervals. I soon discontinued the potash, as it made the urine alkaline and fetid. Ergot, in combination with iron, was given for some months, but with no benefit. On empirical grounds I tried belladonna, balsam of copaiba, tincture of apis, etc., but with negative results. With the approach of warm weather the following spring, the urticarial attacks became more frequent, and the aspect of the eruption was as unpromising as ever.

I lost sight of the case for over a year. In August last the mother again brought the child to me for treatment. From notes taken at that time I read: A marked change may be observed in the appearance of the eruption. Only two or three of the tubercular prominences are to be seen, but the pigmented spots are more thickly disseminated. With the exception of a limited area of healthy skin at the root of the nose and over the malar prominences, the eruption covers the entire surface of the body; the palms of the hands and soles of the feet are profusely studded. They may be traced up into the hair, but do not occupy the superior region of the scalp; they are most abundant over the occipital portion, where the head presses the pillow in lying. A number may be seen upon the eyelids. The left upper lid was occupied for a while by one of the tubercular infiltrations, which prevented the retraction of the lid, compelling the patient to keep the eye partially closed. It was soon absorbed, leaving no trace but a patch of pigmented skin strikingly suggestive, both in outline and color, of a patch of xanthelasma. A few may be seen upon the penis and scrotum; they are numerous in the perineal and anal region, extending quite to the margin of the anus.

On the trunk the finger cannot be placed upon a sound portion of skin. The spots have coalesced at their margins and lost their distinctive form, exhibiting a configuration altogether bizarre and impossible to describe. On the limbs the spots are abundant, but generally, discrete.

The mucous membrane of the palate and fauces is seen to be occupied by these spots, although the yellowish hue characteristic of the surface-eruption is wanting.

The color of the spots varies from a pinkish to a yellowish-brown tint, which deepens into a dark-red, almost livid hue, when the surface is hyperæmic. Upon the neck, chest, abdomen, and back, there is a decidedly greenish cast in the pigmentation. These spots, upon pressure, lose their reddish tinge, but the yellowish stain remains unaltered. Their coloration is largely influenced by the vascularity of the region which they occupy. Upon the forehead, for instance, they are pale and indistinct, except when the circulation is quickened from accidental causes.

Most of the spots are elevated,—some of them imparting a soft, velvety feel, like the sensation communicated to the finger when passed over the surface of a mole. A close examination of some of the patches reveals a condition altogether unique, according to my observation, and which I have never seen described in the textbooks. There is a distinct hypertrophy of the skin, which seems to be punched up and lying loose, very much as the epidermis of a blister from which the fluid has partially exuded. This redundant skin ordinarily lies in minute wrinkles or folds, which, during the urticarial orgasm, become distended and form the characteristic wheals. This could be verified at any time by irritating an individual patch with the point of a pin or other instrument. This condition is much more noticeable in the warm weather, when the disease is aggravated and all its distinctive features intensified in character.

Other patches, not so elevated, exhibited a curiously-checkered appearance. They seemed to be studded with a number of small, flattened papules, separated by transverse lines or furrows,—an appearance not unlike that of the skin over the knuckles and exposed joints when viewed through a magnifying-glass. By putting the skin upon the stretch, these elevations could be obliterated temporarily.

The urticarial attacks occur at variable intervals in warm weather, sometimes as often as once a week,—in winter not nearly so often. The exciting causes cannot always be determined; most generally, they can be traced to improprieties in diet. They may be produced by mental emotions, as fright, anger, etc., through the direct agency of the sympathetic. An intense hyperæmia of the skin is occasioned by the least excitement. The child had no fear of me, yet when I proceeded to examine him the whole cutaneous surface became injected, presenting the appearance of one suffering from a high fever. There was a marked hyperesthesia of the skin. So exquisite was the sensibility that the contact of the air upon a surface not ordinarily exposed would cause an irritation, which the child would betray by uneasy sensations and a disposition to scratch. Pruritus has been a constant element.

The slightest irritation of the skin would develop wheals. The rapidity and extent of this manifestation would depend upon the degree of severity of the irritation. The effect seemed to be limited to the region supplied by the affected nerves. For example, in marking one of the protuberances above referred to with indelible ink, a circular wheal, corresponding to the line drawn by the pen, would neatly circumscribe the mass. This morbid susceptibility was much heightened in the patches of diseased skin. Irritation of a sound portion of skin selected on the arm, for example, required from four to five minutes to develop a wheal, while the same irritation applied to a contiguous diseased patch produced this result in from two to three minutes.

Upon drawing the point of a blunt instrument over the surface,

the following phenomena were observed: first, a slight paleness—deepening almost immediately into a deep red—spread over a broad band of hyperæmic surface. In about ninety seconds a white welt of œdematosus tissue rose in the central portion of this band, and in from two to three minutes the wheal, corresponding to the tract of irritation, was completely developed. It remained more or less distinct from thirty to forty minutes, then commenced to subside. Usually it was from five to seven hours before all traces had disappeared.

In this connection, I would state that there was a marked difference in the duration of the wheals produced through sympathetic influence, and those factitiously developed. Some time ago I had the case photographed. By moderately-firm pressure with a blunt instrument, I traced the letters U, P on the back, between the shoulders. In three minutes they appeared in the form of fully-developed wheals. The child was much frightened and excited, and I observed on the neck, chest, and sides a copious eruption of wheals, which corresponded exactly with the configuration of the patches. These last subsided in a few minutes after the child was quieted, while those artificially produced remained out several hours, leaving in their train a half-dozen or more semi-globular protuberances, which did not disappear for several days. I have observed, as the effect of an unusually severe irritation, small vesicles, and at one time a large bulla, upon the surface of the prominences, but they dried up in the course of four or five days. There has never been any suppuration. The temperature of the skin, when actively hyperæmic, was raised from two to three degrees. Repeated experiments with Stewart's surface-thermometer confirmed this observation.

To complete this history, I will state that the eruption has not materially affected the child's health. He is well nourished and unusually well developed for one of his age. He has frequent attacks of epistaxis, more or less violent, which usually come on at night; once or twice they have proven quite threatening in severity. He has never had jaundice or any symptoms of liver derangement. The most rigid investigation failed to elicit the history of any skin disease in either the father's or mother's family. I may remark that before the child came under my care he had been subjected to a vigorous antispecific treatment, the eruption having been mistaken for a *papular syphilide*.

As I have already greatly exceeded the proposed limits of this paper, I can only refer briefly to the more distinctive features of the four cases presented before the London Clinical Society.

Mr. W. Morant Baker's case was exhibited Dec. 12, 1874.\* The patient was a male child 12 months old. Eruption first appeared when the child was 6 weeks old. It consists of papules and tubercles of various sizes from that of a pea to a kidney bean, some nummular,

\* Transactions London Clinical Society, Vol. VIII., 1875.

some irregularly oval. In some parts, as if by confluence of tubercles, it appears in the form of irregular wheals and patches. These tubercles and patches are raised above the surface of the skin like urticaria rash, smooth and flattened; they differ but little in consistence from the healthy skin; somewhat tougher. They have a pale-yellowish or yellowish-pink tinge. The color varies from decided pink to a dull red. There was no sign of the eruption on the palms or soles. The mucous membrane of the mouth and palate was unaffected. Eruption itches but little, and only occasionally. When one of the tubercles is rubbed or scratched, it appears as if blistered or nettle-stung. This subsided in an hour or two. Child perfectly healthy in other respects. Little change occurred in character of eruption from this date until his death, two years later.

Dr. Tilbury Fox's case was exhibited Dec. 12, 1874.\* The patient was a male child 26 months old. Eruption first developed when he was 6 weeks old; now covers entire body, head, palms and soles, and mucous membrane of mouth and palate. The spots vary in size from a split pea to a shilling, many in size and shape like an almond. When they first appear they are of dullish-red or dusky copper color, but become paler, and after a time light buff-colored. The patches feel somewhat like a thick piece of chamois leather. The spots are all elevated above the surface, the large ones almost, if not quite, one-quarter of an inch. The patches present in some cases an aspect of a uniform infiltration; most of them, however, are made up of a congeries of indistinctly-marked projections, which seem to be seated at the hair-follicles. In the large swellings the separateness of the projections seems lost in the close amalgamation, so to speak, of the individual projections. Some patches may be likened to a hypertrophy of the skin, involving especially the follicles of the skin, and of a buff color.

Dr. Thomas Barlow's case was exhibited May 25, 1877.† The patient was a female child aged about 2 years. The eruption first appeared when the child was 3 months old, in the form of round, brown patches upon the chest, which soon spread over the trunk. Over the entire body, with the exception of the face, hands, and feet, were numerous pigmented patches. They were slightly raised above the surface, and varied in size from the area of a pea to that of a shilling. They were of a uniform brownish color, with a dash of olive in it, not unlike the color of chloasma, but darker. Scratching will easily bring out wheals. Simply handling the child will produce same result.

Dr. Sangster's case was exhibited April 26, 1878.‡ The patient was a male child, aged 2 years. The eruption first commenced when the child was 2 months old, as a red mottled rash on abdomen, thought to be measles; gradually spread first over the trunk and then the extremities, leaving the hands and feet free. It now ap-

\* Transactions London Clinical Society, Vol. VIII., 1875.

† Ibid., Vol. IX., 1877.

‡ London Lancet, May 11, 1878, p. 683.

pears as a buff-colored and red-mottled rash. The diseased patches are slightly raised, but with no obvious increase in substance. On pressure, the red color disappeared, leaving a pale buff discolouration. Child healthy in other respects. There was much pruritus, and scratching produced urticarial wheals. These "bumps," as the mother called them, would rise on the slightest irritation.\*

These cases, it would appear from a rapid glance, belong to the same category with the one I have described, representing, no doubt, different stages of the same disease. The appearance of a mottled rash at an early age, the elevated spots of thickened and pigmented skin, and the easy production of urticarial wheals, are features which they all possess in common. Of the various names proposed to designate this affection, that suggested by Dr. Sangster, viz., *Urticaria Pigmentosa*, is, I think, the most felicitously chosen.

As I have said before, these cases have provoked much discussion as to their true nature. Dr. Tilbury Fox asserts that this disease is clinically and pathologically distinct from urticaria.

Dr. Hutchinson and others regard it as an *Urticaria Persans*, occurring in connection with a pruriginous condition of the skin,—the thickening and pigmentation being the result of the long-persistent inflammation.

There can be, it seems to me, no question that its clinical history identifies it with urticaria. The urticarial element is the salient, distinctive feature. The hypertrophy and pigmentation of the skin are readily explicable from a consideration of the morbid processes to which it has been constantly subjected for so long a time. We cannot well conceive of a frequently recurring condition of active hyperæmia with exudation, without permanent nutritive disturbances, such as increase of structure and pigmentation.

The pathological nature of the nodular masses which have been so marked a feature in this case, especially in its earlier stages, cannot, of course, be satisfactorily determined without microscopical

\* Since the above was put in type, I find that Nettleship (*British Medical Journal*, September 18, 1869, p. 323) reported a case of chronic urticaria having brown stains of nearly two years' duration. The patient was a female child æt. 2 years, and was treated in the Hospital for Diseases of the Skin (Blackfriars'). The eruption was peculiar in leaving stains of a light-brown color, their tint being very like that of chloasma. It began when the child was 3 months old, the mother says, as white lumps like the sting of a nettle; these itch severely, and on subsiding leave the curious brown stains above mentioned. The rash thickly covered the neck and trunk, the extremities being more sparsely affected. There were a few brown stains of former wheals at the margin of the scalp on the forehead. There were no red wheals, but some slightly-raised patches of light-brown color, with slight congestion, and some stains of former wheals. The wheals were of uniform size, and about as large as threepenny pieces. It was noticed that a scratch with the finger-nail produced in a few minutes an ordinary urticarial wheal. At a subsequent occasion a number of recent patches of erythematous and elevated skin were observed that had not yet become brown. Nettleship remarks, "We do not find any mention of a similar condition in our standard works."

The existence of the above case seems to have been overlooked by Drs. Fox, Hutchinson, and others, as no allusion is made to it in their discussions of the four cases presented before the London Clinical Society.

investigation. In the absence of positive knowledge, I would suggest that they may be caused by thrombosis of the lymphatic vessels, and would explain their production as follows: The urticarial phenomena are due to a paralysis of the vaso-motor nerves of a reflex character, the point of departure of which may be irritation of the nerves of the gastro-intestinal mucous membrane, or the sensory nerves of the skin. As a result, there is a dilatation of the cutaneous vessels, their walls become more porous, and serum or plasma is exuded more rapidly than can be carried away by the lymphatics, and we have the raised oedematous wheals. After a variable time, when the equilibrium between the lateral blood pressure and the action of the lymphatics is re-established, this exudation is absorbed. Sometimes, however, from accidental conditions, it may be an unusually severe irritation, there is an occlusion of the lymphatic vessels at one or more points, which causes an accumulation of the products of exudation, and we have, as an epiphénoménon, the nodular swellings.

The ephemeral nature of these lesions suggests an analogy with some of the manifestations of erythema, a disease with which urticaria, as is well known, is closely allied. Besides their fugitive character they have other points in common: they occur most frequently in warm weather; they come out at intervals in the form of crops; their average duration is about two weeks, and they never suppurate. Unlike the nodes of erythema, they disappear without desquamation, leaving a patch of thickened, pigmented skin. Whether the elevated patches above described have each been the seat of a nodular swelling, and represent changes effected through its development and resorption, cannot be determined with absolute certainty. I incline to the view that such has been the case.

Another question of importance is, Does the present condition of the eruption represent the sum total of all the pigmented spots that have appeared from the first, or has there been a slow series of changes in which old spots have entirely disappeared, and new ones taken their places? The very multiplicity of the spots renders it difficult to obtain exact knowledge on this point. They are certainly much more numerous than they were two years ago, while on the other hand many of them are faint and indistinct, as if on the point of vanishing. If the spots actually do disappear, leaving the skin sound and healthy, it should affect favorably our prognosis as to ultimate recovery.

## ACNE IN MILL WORKERS.

BY H. S. PURDON, M.D.,

Physician to the Belfast Hospital for Skin Diseases, Lecturer on Clinical Medicine, and Physician to the Royal Hospital, etc.

RESIDING in Belfast, the great centre of the flax and linen manufacture of Ireland, I have had many opportunities of observing a peculiar eruption of acne, usually confined to the upper extremities, in those persons employed in flax-spinning mills. Those who are attacked are generally the "spinners" and "doffers," the occupation of the last named being to "doff" or remove the bobbins from the machines, and to clean and oil the same. The "doffers" are generally young girls. The eruption is always well marked on forearms, the skin being dry and harsh to the touch and covered with a papulo-pustular eruption, whilst innumerable black specks or comedones are visible, showing the nature of the complaint, viz., obstruction of a sebaceous follicle. Before the eruption "comes to a head" it has a decidedly "shotty" feel, similar to what is felt in smallpox. During an epidemic of variola which we had here some years ago this peculiar feel of the incipient stage often confused me, especially if feverish symptoms were present. The eruption is frequently observed on the face, and is accounted for by the fact of the person wiping her face, whilst it is perspiring, with oily hands.

The cause of the disease is the oil that is used for the machinery, and also the oil contained in the flax. Dr. C. D. Purdon, in his book on the "Diseases of Workers in Flax Mills," informs us that "another disease is a papular eruption that attacks the exposed parts of the body, and is caused by the action of the flax-water on the skin of young persons and children; those that are badly nourished suffering far more than others. Adults are not affected by it. A certain description of Russian flax produces a pustular eruption so like variola, that during an epidemic of it the medical attendant was almost deceived at first." Professor Hodges, of this town, has obtained from flax fibre a volatile oil of a yellow color, which has an agreeable, penetrating odor, and suggests the peculiar smell remarked on entering a room in which it is stored. The fibre also contains wax, a peculiar green resin, tannin, etc. It is right, however, to note that Dr. Martin, of Portlaw, has observed this eruption to be more prevalent when certain kinds of mineral oil were used in their jute factory.

As for treatment,—which is not of much use as long as the person is employed in the mill,—glycerine may be given internally, as proposed first by M. Gubler in the treatment of ordinary acne. Locally, plenty of soap and hot water is all that is required, or if the patient can afford it, a little ozokerine smeared over arms and face

daily, and washed off at night with juniper tar soap, is useful. Some years ago I tried ozokerit in skin diseases, and published the result in a short paper (*Dublin Quarterly Journal of Medicine*); since then Messrs. Field, of Lambeth, London, have introduced ozokerine as a basis for ointment, etc. It is cheaper than vaseline, cleaner and more healing in its nature, and only requires to be known to come into general use.

In this short communication I have no space to mention any of the other complaints prevalent among the workers in mills, such as onychia, edema of legs and ankles, varicose veins, and ulcers, or the peculiar affection called "mill fever," which attacks new hands when they have been at work for a few days; the symptoms being rigors, nausea, vomiting, quickly followed by pain in the head, thirst, heat of skin, etc.

Those engaged in bleaching yarn when it is boiled in a certain kind of lye, which is an irritant, suffer from eczema rimosum of hands, and of so severe a character that the fissures bleed frequently. The disease commences in about twenty-four hours after beginning work, and in two or three days the pain is so great that they have to discontinue work until the parts are healed.

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## NOTES OF FOUR CASES OF LEPROSY IN MINNESOTA.\*

BY CHR. GRÖNVOLD, M.D.,  
Norway, Minnesota.

### I. ANÆSTHETIC FORM OF ELEPHANTIASIS GRÆCORUM.

CHRISTEN JOHNSON HAUGLUM, native of Arnafjord, Sogn, Norway, came to America in 1861, and settled in Long Prairie, Illinois. Eight weeks afterwards, he went to Goodhue County, Minnesota, where he is now living, in the town of Wanagering.

When he was 24 years old, he was hale, hearty, light-footed and sharp-sighted, and had never been ill. He had been accustomed both to fishing in the sea and hunting on the mountains. He only remembers that during the spring of each year he would be troubled for some days with an eruption upon the lower part of the face, which would itch, and often result in soreness of the surface from scratching. This was, however, of small moment, though it has recurred with tolerable regularity to the present date.

In 1856 he was made ill, as he thinks, by exposure to cold during

\* The cases here described were originally a part of the full and unpublished report of the committee on the Statistics of Skin Diseases in the United States, appointed by the American Dermatological Association. The language of the author has been slightly changed, whenever necessary in consequence of his scarcely noticeable unfamiliarity with the English tongue.—J. N. H.

his excursions upon the sea and on the mountains. He was then confined to his bed for seven weeks, and for some time afterwards was unable to do any work. The disease began with chills, and was characterized by heated skin, headache, pain, generalized and finally located in the left thigh, with a disposition to stretch the limbs, heaviness, drowsiness, and insomnia for several days and nights. This was succeeded by a sleep which lasted without interruption night and day for several days. Then he had a cough, from which he still suffers, with distressing dyspnœa and abundant haemoptysis, the latter symptom often returning since the date mentioned. After this attack he seemed to be quite sensitive to cold, but declares that in other respects he was perfectly well.

He found, however, that once or twice yearly he would suffer from similar attacks, each accompanied by severe pain in the left thigh, usually in the spring of the year, when the ice was melting, but frequently also in the fall, when the frost set in. He would, on these occasions, generally be confined to his bed for from three to eight days, feeling for some time afterwards very uncomfortable with anorexia and debility. Neither at this time nor for years afterward did he suffer from symptoms of cutaneous disease, such as tingling, pricking, anaesthesia, or pemphigoid lesions.

During his voyage across the Atlantic, in 1861, he had an attack of shivering and fever, more severe than any heretofore experienced. He recovered so far as to be able to work in the harvest-field when he reached Illinois, but later had such severe cough, dyspnœa, and haemoptysis that he thought he would soon die. He however recovered sufficiently to remove to Minnesota.

Here his attacks, though recurring once or twice annually, were less prolonged and severe than formerly. The shivering fits would last for several hours, but when the fever and pain were relieved he would regain his appetite and feeling of general well-being with promptness, and without the periods of malaise heretofore experienced. In a few years, however, his attention was attracted to an increasing numbness in several parts of the extremities. In 1870, sensation had considerably diminished on the peroneal side of the legs and on the ulnar side of the forearms, and corresponding surfaces of the hands.

In 1871, excoriations appeared upon the nates, degenerating into sores, which did not heal for three months.

In 1872, the hair of the eyebrows disappeared, followed in the ensuing year by the eyelashes.

In June of 1876 the feet and legs commenced to swell, and the tumefaction, in the course of two months, involved, to a great degree, the entire lower extremities, the scrotum, and, to some extent, the arms and hands. All the swollen parts were more or less anaesthetic, but this symptom was more marked on the left side. He was in the habit of pricking the skin with a needle to relieve the tension, and from the punctures thus produced there immediately flowed a copious, limpid, yellowish fluid, in quantity sufficient to

form small streams. Under the influence of warm cataplasms, this discharge would continue during the night, and in the morning considerably diminish the size of the extremities. Often the amount discharged in twenty-four hours would equal two quarts. He commenced to grow hoarse, and the old cough and dyspnoea returned with severity. By October the swelling had decreased to a considerable extent, but there was soreness of the affected parts, cephalalgia, failure of the eyesight, and frequent fits of shivering. In December the swelling had disappeared from all places except the left foot and a portion of the fingers and hands. The parts formerly swollen then became hyperæsthetic, so that the slightest touch caused pain.

During the winter he steadily improved, and by the ensuing summer he was able to move around again. Only the left foot was swollen, but a more complete and increasing anæsthesia succeeded to the former condition of hyperæsthesia.

In the fall of 1877 he had a severe recurrence of his former symptoms, of a character, however, somewhat different from that noted before. A severe headache, especially located above the root of the nose, was followed with a double acute iritis, severe pain, and a copious discharge. The eyes felt as if they were squeezed backward in their orbits, and this pain, when no atropia was used, would be continuous day and night; it did not completely disappear for the next nine months. Some time after the onset of this attack, a painful tumor occurred below and behind the left ear, which in four days opened, and is still discharging.

About fourteen days after this, in November of 1877, there appeared on the sides of the left foot six small bluish spots, soon followed by sloughing and exposure of the underlying bone. At the same time a bulla, as large as a twenty-five-cent piece, appeared beneath the heel. This burst and exposed a dark red floor which soon became black and fissured, the fissure extending to the os calcis. Further sloughing extended and deepened this, till an excavated ulcer was formed with the os calcis revealed at the bottom, discharging a stinking, ichorous, viscid matter. This communicated subsequently with other sores, which in a short time after healed. The ligaments were softened, almost disintegrated, and their connections so loose that the part of the foot in front of this sore seemed attached merely by the skin, and the os calcis so nearly disengaged that the nurse thought it would fall out and tried to remove it, but found some posterior attachments remaining which held it in place.

At the present time (September, 1878), this bone has, on account of the weight of the foot resting upon it, been dislocated forwards, under and at the side of the other tarsal and metatarsal bones, so that the foot in front of the sore presents a very swollen and unshapely appearance. It is a mere insensitive bag of half-disintegrated bones and jelly-like muscles, between which the finger can be inserted to its whole length in different directions. The ulcer is oblong, three by two inches in extent, with callous undermined

borders and a pallid slimy floor of muscles. An exposed articular facet of the astragalus has taken the place of the dislocated os calcis, which in its turn is moving forward, so that the ends of the tibia and fibula will soon appear at the bottom of the sore. The discharge is a thin limpid fluid, in quantity sufficient to drench the dressings, sheets, and mattress. As the foot is quite loosely attached, it can readily be carried up along the leg, a position it will assume whenever the foot is stretched and the toes pressed against anything.

At present he is almost without pain, owing possibly to the free discharge or to the periodicity of the disease. Walking is of course impossible, and he has not the strength to use crutches. Before the os calcis was dislocated he essayed to take a step, but the effort induced severe hemorrhage. The anaesthesia is complete to above the ankle, a few patches on the inside of the foot excepted. In the remaining portions of the same leg there is partial anaesthesia, especially below the knee and on the peroneal side; also in corresponding parts of the other leg and over the hands and forearms, chiefly on the ulnar side. The sensation in the lower side of the face is also somewhat blunted.

The skin of the affected parts is dry and withered, peeling off in thin layers; on the left leg it is thicker, resembling dried fish-skin. About the sore in the foot it is considerably thickened. Sweat is secreted only on the forehead and trunk, especially the upper part of the latter.

The general appearance is that of wasting and emaciation, with muscular atrophy, especially about the anaesthetic surfaces. Sight is much impaired in both eyes, especially the left, where the pupil is obstructed by deposits upon the capsule of the lens, and the pupillary margin exhibits the fringes resulting from iritis. The eyes also are moister than normal, and the lids are glued together every morning. The lids and brows are destitute of hair. The upper lids are thin; and he complains of a tendency to ptosis, especially upon the left side, when the eyelids have been raised for any length of time. The lower lids have lost their fulness in part, but the tarsal border is closely applied to the globe, and the lids cover the eyes well. The left inner canthus is especially large; the lachrymal caruncles have almost gone. The left half of the mouth is partially paralyzed, the lips being relaxed, though they shut together fairly well. The mucous membranes of the mouth and pharynx are pale, but in other respects normal, though there is occasional dysphagia. The voice is clear and natural, when not affected with "a cold." Hearing is impaired on the left side. He states that his sense of taste is normal, though it is probably impaired. He likes some articles; dislikes sweet and salted food, and complains frequently of a bad taste in the mouth. The appetite is good; the bowels regular. The Schneiderian membrane often feels to him dry, though he thinks his sense of smell is unimpaired. The fingers of both hands are bent into the palms; they

are very thin, crooked, claw-like, and clubbed at the extremity ; this latter appearance being due to the large, high-arched, rounded, flesh-colored, and inverted nails, which are almost continuous with the flesh, and are only recognizable as of different structure on close inspection. The nails of the toes, which have begun to fall off, are of similar appearance.

He has six or seven healthy children from 6 to 21 years old. Only one of his relatives, so far as he knows, is affected with a similar disease,—the brother of his mother's father.

If the patient's statements are correct regarding the development of his disease previous to 1873, when it was first brought under surveillance, it differs from those previously described by Professors Boeck and Danielssen in this, that no pemphigoid eruption appeared until the later stages of the disease were attained.

*Case II.*—Peter Benonison Bistranden, born in 1843, in Losoten, Norway. His father's brother was leprous. Up to the year 1868 he was quite well. In 1869 he came to America on account of his health. Right leg anaesthetic. In 1876 he had acute iritis. In 1878 he died of anaesthetic leprosy.

### III. TUBERCULAR FORM OF ELEPHANTIASIS GRÆCORUM.

Hjelmer Henrikson Dybaa, nativity in Vingvaagen, Vernes, Thondhjem Stift, Norway, 1849, came to Zumbrota, Goodhue Co., Minn., in 1869. He did not suffer from disease, to his knowledge, before 1873, when, after some illness, he discovered tubercles and sores in several places upon the extremities. Every year he has suffered from attacks of indisposition. In January, 1878, there were tubercles on the ulnar side of the right arm and along the peroneal muscles of the right leg, with anaesthesia of those parts. He had also some tubercles upon the forehead, which, he explains, bled freely when torn. The skin of the affected parts is rough and thickened, especially over the face; upon the legs and arms there is desquamation; small, brown, elevated, and slightly anaesthetic patches of *morpheæ nigra* are disseminated over the body, especially over the back. The mucous membranes of the nose and throat are affected; his voice is rough and hoarse; his nostrils obstructed by crusts. The conjunctivæ are injected. He describes the sensation of the flow of blood through the body as similar to the effect produced by the prick of needles or arrows. He suffers frequently from headache, heaviness, and drowsiness; can sleep at any time, day or night. Appetite and bowels normal.

He states that none of his relatives have been leprous. When 19 years of age he was engaged as a servant at the house of a leper—Eyvind Hansen Gulbrandsvik—in his native parish. Here he remained one year before coming to America, and he thinks he was then infected with the disease.

*Case IV.*—Hans Marcussen Dyrdal. Case observed and reported on by Professor Boeck, of Christiania (now deceased). Steadily grew worse after that time, and died in 1878 of tubercular leprosy.

## REMARKS ON LEPROSY IN MADEIRA.\*

BY W. W. IRELAND,  
Funchal, Madeira.

**A**S Madeira, at its discovery, in 1419, was uninhabited, it was at once peopled by Portuguese settlers. But many slaves were carried away from the African coast, who, intermarrying with the inhabitants, have produced a race evidently a mixture of the European and African, though in many cases the European blood has remained almost pure. As leprosy still exists both in Portugal and on the African coast, it may originally have come either from the one place or the other,—perhaps from Portugal, since it is unlikely the Portuguese would take much trouble to import lepers. At any rate, leprosy has existed here from time immemorial. According to J. Adams, who wrote in 1801, in the course of a century 899 lepers, 526 of whom were men and 373 women, were received into the lazaretto, that is, about 9 yearly admissions. Dr. Barral<sup>†</sup> counted 26 lepers in 1852; Dr. Schultze,<sup>‡</sup> who was here in 1863, says that the leper hospital contained in his time from 25 to 35 patients, and that there were about twice as many others suffering from the same disease who remained at large. In 1868 I found not more than twenty patients in the leper hospital. Most of these patients come from Ponta do Sol, a district on the coast to the west of Funchal, inhabited by poor fishermen, who live for three or four months upon yams<sup>§</sup> and salt fish. A good number also come from the parish of Paul do Mar, a few miles farther west. The disease is *lepra tuberosa*,—enlargements of the skin, or subcutaneous tissue, from the size of a bean to that of a walnut, scattered over the body, but more commonly on the face and limbs. *Elephantiasis Arabum* is rare. The disease is regarded here as hereditary from both parents, and not contagious. The husband and wife do not infect one another. Since the Portuguese doctors have begun to disbelieve in its contagiousness, many of the lepers are allowed to go at large. Though the leper hospital is an old building, the accommodation is tolerable, certainly much superior to the homes of the poorer classes in Madeira. The food is said to be sufficient and of good quality. I saw no cases of elephantiasis. All the patients were out of bed and able to go about. The men were in one ward, the women were in another. The nurse slept in the same ward with the female patients, and handled them freely without any fear of

\* This communication was found among the papers of the late Sir James Y. Simpson, and was forwarded for publication by Dr. Lawson Tait, of Birmingham, England. Although written some time since, the remarks are interesting, and contribute to our knowledge of the disease.—ED.

† Barral, *Noticia sobre o Clima do Funchal, etc.* Lisbon, 1854, pp. 146–7.

‡ Schultze, *Die Insel Madeira.* Stuttgart, 1864, pp. 121–2.

§ This is the *Inhame* or *Colocasia esculentia* of botanists.

contagion. The women who washed the patients' clothes are sometimes troubled with skin eruptions, but never with leprosy. In the case of one young man, with large, broad, pinkish, dermic tubercles on the face, the disease had appeared at the age of three years, and had now lasted fourteen years. Occasionally it endures longer, but generally ends in death. His father had been a leper and his sister was in the same hospital. In one case the patient's face and legs were covered with cicatrices. The man had been treated for two years in the town hospital, by Dr. Juvenal de Ornellas, with arsenical preparations, and had been dismissed much improved. Subsequently falling off in health, he had become an inmate of the leper hospital. There were few granulations on his body, and the disease, if not arrested, seemed to be making little progress, at least outwardly. His voice was much affected. When the disease ends fatally, it often does so by causing growths and erosions in the throat and air-passages. Sometimes the nose is eaten away by a slow process of ulceration. The disease is said to commence with an eruption like that of urticaria.

The following remarks bearing on the subject are translated from the work of Dr. Schultze, on the Island of Madeira:

"Tubercular leprosy is found less frequently connected with tuberculosis of the lungs than with that of the glands. It is somewhat more common among males than among females, and becomes less frequent towards the marriageable age. Patients with it seldom pass much the age of fifty years. The Portuguese physicians tell me that leprous women in Madeira become sterile very early, the catamenia cease completely, the breasts atrophy, and sexual instincts become extinct. In other regions, as in Brazil and Paraguay, where leprosy is also endemic, quite other observations have been made; the genital functions remain entirely undisturbed by the disease, and even nymphomania has often been observed."

#### NOTES ON THE LOCAL TREATMENT OF CERTAIN DISEASES OF THE SKIN.\*

BY L. DUNCAN BULKLEY, A.M., M.D.,

Physician to the Skin Department, Demilt Dispensary, New York; Attending Physician for Skin and Venereal Diseases at the New York Hospital, Out-patient Department, etc.

XXV. *Pruritus* (continued).—In the former portion of this article we noticed the subject of general pruritus, giving certain

\* These notes are intended to report, for the use of the general practitioner, the local measures in common use by the writer in the treatment of diseases of the skin. It is not intended that they shall be exhaustive, nor that the measures are recommended to the exclusion of constitutional treatment. The formulæ are not claimed as original, although some of them may be. These "Notes" are continued from pages 212 and 307 of vol. ii., pages 24, 127, and 314 of vol. iii., and pages 49, 225, and 315 of vol. iv.

cautions in regard to eliminating other diseases or causes, as parasitic, etc., pruritus being properly only the itching condition of the skin, independent of any actual cutaneous lesions other than those caused by scratching or by the applications made. We also spoke of the importance of considering the internal causes and the general condition of the patient in every case of pruritus, and as we have here to do only with local measures, no further mention of these points will be made.

There are certain regions which are very apt to be affected by a local pruritus, which at times is terribly distressing,—these are the anus and genital region. For this local itching one of the most effectual local measures which can be employed is hot water. And it should be used very hot, so that the application of it is uncomfortable to the hands. In pruritus of the anus and vulva, I direct that a cloth—as a handkerchief—shall be dipped in the water and held firmly against the part until the heat is dissipated, when the application is renewed once or twice more. The part is *not* to be *bathed* in the water, as the term is ordinarily used, but to be treated as above described. Care should be taken that the operation is not prolonged, and that the water is really hot, or a reaction sets in and the parts are weakened instead of strengthened by the water; two or three minutes generally suffices.

After the application of the water, some local remedy must be used at once, and the one perhaps most generally serviceable in lighter cases is carbolic acid, either in ointment or solution; ten to twenty grains to the ounce of cosmoline often gives great relief; it may, of course, be used much stronger. In pruritus ani, after the hot-water applications, I have repeatedly found the best application to be equal parts of the unguentum belladonnae and the unguentum hydrargyri, well rubbed together, and inserted on cotton batting as deeply as possible.

It must never be forgotten that the most obstinate and distressing pruritus ani may be due to the presence of minute cracks and fissures, and the very best method of relieving the itching is to pencil the fissures with a stick of nitrate of silver, tucking in a bit of cotton afterwards, under which they generally heal promptly and kindly. Nitrate of silver is also very conveniently and effectively applied in itching of the anus and genitals, in solution in the spiritus etheris nitrosi, of a strength of from five to twenty grains to the ounce. Very great relief—and I have seen cure to follow—is obtained in pruritus scroti from the following wash: R.—Bismuth. subnitrat., 3ij; acidi hydrocyan. dil., 3ij; misturæ amygdalæ, 3iv; M. To be shaken and well applied. The poisonous character of the hydrocyanic acid must always be borne in mind, and the wash should not be used to surfaces largely abraded.

No little relief is afforded to pruritus, both local and general, from the compound of chloral and camphor, which I had the honor of introducing to the profession in this connection some time ago. It is formed by rubbing together the hydrate of chloral and pow-

dered camphor in a mortar until a liquid results, and then adding this to ointment. Ordinarily a drachm of each in the ounce will be sufficient, but this amount may be doubled, if necessary; or sometimes a lesser quantity will suffice, while even that first mentioned may prove too stimulating. When applied to a denuded surface, this remedy causes considerable burning.

In intractable itching about the genitals, the possibility of a parasitic cause must always be borne in mind, and the crab-louse may sometimes be found when least suspected. A vegetable parasite may likewise be a cause of this distressing symptom, and a mild case of tinea trichophytina cruris—the eczema marginatum of Hebra—will often long pass unrecognized. Quite lately, Dr. Stevens, of Lebanon, Ohio, reported some cases of pruritus vulvæ cured by the local use of sulphurous acid; possibly in these cases the mucous membrane itself may be the seat of a parasite.

Caustic potash is a very valuable anti-pruritic, and when properly applied is of the greatest service in pruritus of the vulva. In weak solution,—ten to twenty grains to the ounce, with a little glycerine,—it may be applied freely, the parts being then covered with some mild unguent or the carbolic acid ointment, spread on linen and laid on, and tucked in between the labia. In stronger solution,—half a drachm to one or even two drachms to the ounce,—it is to be rubbed on less frequently, but more actively, with a view to produce abrasions of the surface, allow exudation, and thus to cause absorption of thickened tissue; the applications cause much burning, but the relief afforded to an obstinate pruritus quite compensates for this.

The subject of itching is too vast a one to be more than touched upon in such an article as this, and I will only add that in the great majority of the cases of pruritus the itching is but secondary, a symptom the removal of whose cause must be sought for in other measures than those directed against the skin itself.

XXVI. *Psoriasis*.—Some of the more recent observers have been led to consider psoriasis as a purely local disease of the skin, and thus to trust entirely to local measures for its cure. Without entering into the subject other than stating my continued belief in its internal causative relations, and the consequent necessity of constitutional treatment, I will briefly mention the local measures I most rely on.

Foremost must be placed baths, which are well-nigh necessary to remove the scales that the local applications may reach the diseased tissue. The simple warm bath may be taken several times weekly, washing the surface vigorously with some strong soap, as the common yellow bar soap, or the potash soap (*sapo viridis*) now so well known. Where expense is no object I prefer to medicate the water with carbonates of potash and soda, and borax, as before described; the alkalies dissolve off the scales, and are undoubtedly of much direct benefit to the eruption.

The most promising agent to apply to the disease after the bath

is certainly chrysophanic acid, with which the readers of the ARCHIVES are already well acquainted. I have used it very considerably, but am not as enthusiastic over the results obtained as are some. Unquestionably, it produces more immediate effects on the skin than any other agent with which we are now acquainted, but I have seen the eruption resist final cure for some time, while the annoyance to the patient in the staining of the skin, hair, and clothes renders it almost if not quite inapplicable in many cases; nor do we yet know whether the results will be much if any more permanent than those otherwise obtained. I have employed it in strengths varying from some grains to two drachms in the ounce of ointment, and have seen the erythematous inflammation of the skin occur in a number of persons from quite different strengths. The ointment should always be prepared by melting the excipient, dissolving the acid in it for some little time over a water-bath, and stirring until cold. It is to be well and thoroughly rubbed into each of the affected spots, which will then appear of a much lighter color than the surrounding skin, which is dyed of a brownish-purple. The applications are to be made once or twice a day; some have advised them thrice daily, but I have sometimes found that a single application each night has in a short time proved too stimulating, causing such an abundant erythematous eruption that they could not be repeated. The applications should be continued until the psoriasis spots have ceased to be visible as light-colored islands in the purplish background, and the whole skin is tinted uniformly by the ointment.

The older methods of local treatment are of course still of value in psoriasis; chronic and obstinate cases sometimes yield quite promptly to citrine ointment, diluted once or twice, or even used in full strength. The application of pure tar, well rubbed into each patch, and allowed to dry on, will pretty certainly remove them, and in a comparatively short time. Hebra's compound tincture of oil of cade and green soap, well scrubbed into the affected spots, is generally quite efficacious, but the results are not very rapid; it should be followed by an ointment, as the strong white precipitate.

In several instances I have accomplished a speedy removal of certain spots of psoriasis, notably those on exposed surfaces, as on the forehead, by the method of scraping, as with a dermal curette or with a dull knife-blade, until the blood flows; it is well then to rub in a little weaker white precipitate and bismuth ointment.

Very excellent results have been reported by a number of observers with the application of strong acetic acid to each patch; this whitens the surface, destroys the superficial layers of cells, and when the crust comes off it is to be again applied. I have used the acetum cantharidis with success in isolated patches.

It is to be understood that these stronger irritating applications are wholly unsuitable for acutely-developing cases, and not infrequently a delicate skin cannot bear them at all; most of the cases coming for treatment are, however, chronic, and will not only tolerate such irritating measures as have been here mentioned, but will

resist them with marvellous obstinacy. In the acute cases, which are often attended with itching, the warm alkaline and starch baths before alluded to, or wet packs, together with active internal measures, yield far the best results.

XXVII. *Purpura*.—This disease is mentioned in alphabetical order only to remind those little acquainted with the subject that no local measures of any kind are called for; there are no local remedies which can either prevent the recurrence of fresh hemorrhages into the skin, or that can assist in any degree in hastening their removal or absorption. As there are little or no subjective symptoms, as pain, itching, etc., there are no other indications for local treatment. The occasional rheumatic joint pains which accompany some forms of purpura are relieved by hot fomentations, lead and opium wash, etc., and not by any measures which have any special bearing upon the skin lesion.

XXVIII. *Pustula Maligna*.—In this rather rare affection early local treatment is all important. Immediately after infection is clearly demonstrated the site of inoculation should be thoroughly cauterized, potassa fusa being about the best agent to employ, or the actual cautery, as that of Paquelin; nitrate of silver does not penetrate sufficiently. If much inflammation be already present, free crucial incisions should be instantly made, and charcoal poultices wet with chlorinated soda solution should be applied; temporizing is fatal.

(To be continued.)

## CLINICAL REPORTS.

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*An Additional Case of Cleft Palate and Hare-Lip in a Syphilitic Child.*

By THOMAS R. BROWN, M.D., Prof. Clinical and Operative Surgery and Diseases of the Genito-Urinary Organs, College of Physicians and Surgeons, Baltimore, Md.

CASE.—On September 24, 1878, a well-nourished male infant, 3 weeks old, was sent to my clinic by my friend, Dr. B. F. Leonard, to receive treatment for a complete, single hare-lip of the left side. This was associated with a cleft extending through both hard and soft palate. In accordance with what are now recognized as fixed principles, I determined to operate at once, for the purpose of enabling the child to nurse. While the patient was lying upon the operating-table, my colleague, Prof. Bevan, called my attention to an oblong white patch on the right side of the hard palate, near the edge of the cleft. It presented the appearance of a mucous patch. Upon a further inspection there was found a well-marked palmar psoriasis of both hands, extending to the wrist, but chiefly marked upon the fingers. The child was stripped and the rest of its body was carefully examined without finding anything unusual, excepting a conspicuous enlargement of both epitrochlear glands.

In the light of my previous experience that the operation for hare-lip is not apt to succeed in syphilitic cases, on account of the tearing away of the sutures, I adjourned the operation until after specific treatment had been instituted. A "belly-bandage," besmeared with mercurial ointment, was directed to be constantly worn, and the patient dismissed. This plan was followed without interruption for about three weeks, at which time the psoriasis had nearly disappeared, while the patch had undergone no appreciable change.

On October 17, hoping that the syphilitic condition was under control, the usual operation for hare-lip was performed under ether, and the parts held together by the twisted suture. The hemorrhage was slight. In the course of a few days the little patient was presented again, with the sutures torn through. A second attempt was made with a like result. The probability of accomplishing the desired end being, under the circumstances, considered so remote, the operation was postponed indefinitely, while the treatment was directed to be continued. A severe diarrhoea, with wasting, ensued, which compelled the disuse of the mercury. Since the discontinu-

ance of the latter the child's health has much improved. The patch has, at the time of writing (December 4), almost entirely disappeared.

In passing, I may be permitted to state that out of many operations performed by me for hare-lip, I have had no trouble in getting satisfactory union except in two instances, and both of these occurred in syphilitic children. In these the amount of traction required was not unusual, and it seemed as if the tissues simply lacked the sufficient tone to stand the pressure.

*History.*—Mr. and Mrs. N., the parents of our patient, were married January 13, 1867, the mother at the time being four months advanced in pregnancy. This, the first, ended at term in the birth of a healthy female child, which at five years developed a tendency to "fits," somewhat resembling epilepsy. Despite any and all kinds of treatment these continue. Its appearance is that of a very intelligent child. With the exception of the right upper central incisor, all of its incisor teeth are notched. She is well developed, and to observation shows no evidences of disease.

The second pregnancy also ended at full term, and in the birth of a perfectly healthy child, who is still living, now nine years old, and continues well. With the exception of the usual infantile diseases, he has never been sick.

The third pregnancy ended at full term in a still birth. The child looked healthy and was well formed.

The fourth pregnancy also terminated at full term in a still birth. This child is described as being very dark, "rotten," and with the skin peeling off.

The fifth pregnancy was ended at eight months in the delivery of a "dropsical" child, which is also described as "rotten."

The sixth pregnancy is stated to have been ended at six months, by fright at the sight and behavior of a drunken man. The child was dead, and looked all right.

The seventh pregnancy did not advance beyond ten weeks, when an abortion, without any assignable cause, took place.

The eighth pregnancy terminated in the birth of the male child who forms the subject of our sketch.

Both of the parents present a healthy appearance, and the father, who was examined and questioned most closely, positively asserts that the only venereal disease he ever had was gonorrhœa. He gave no history of syphilides, alopecia, iritis, nor of having undergone specific treatment. The mother was investigated as carefully and fully as circumstances would permit. She shows the signs of an exceptionally healthy woman, but states that she once had her hair fall out. Her supply of this at present is large. Neither one of them has any defect in lips or palate.

The above constitute the grounds upon which I rest the claim that the patient under consideration was a victim to hereditary syphilis. Whilst I admit that there are certain missing links which, if present, might serve to place the question at issue beyond dispute,

it seems equally clear that the burden of proof is with the one who would reject syphilis as the most rational explanation of the various points submitted. As to its bearing upon the mouth deformities,—the hare-lip and cleft palate,—this is, of course, another matter. The number of cases already collated by myself and submitted in my first publication, in the ARCHIVES OF DERMATOLOGY, vol. iii., page 307, together with certain cases encountered by other inquirers, is too small to admit yet of any generalization. To what extent the agency of syphilis may be found in connection with this or any other structural abnormalities is still an open question. That it does exercise an influence upon development more or less powerful I have no doubt. A disease which our daily experience demonstrates as being so capable of tissue-destruction in the adult may, with perfect propriety, be invoked to explain many of those lesions met with in the infant. And if this, together with the enormous prevalence of this complaint, be admitted, we will surely find the way open whereby many a vexed question in the matter of congenital defects might be settled.

In consideration of the criticism which followed the article already referred to, it becomes me to say that some of the critics clearly labored under a misapprehension. It was not intended by me to exclude any factor such as heredity, nor even what seems the far-fetched "maternal impression," but simply to call attention to certain points in a matter of pathology which may have been overlooked. As stated at first, so it can be repeated, I believe that in the light of such testimony, and reasoning from analogy, the dangers of which I concede, we can scarcely escape the inference that in the cases offered—*no farther for the present*—there was something more than "a mere coincidence" between the deformities and the disease, but rather the relation of cause and effect.

I would especially invite the attention of the profession to the striking fact that in my first series of cases two of them occurred in one family, the mother suffering from tertiary syphilis, in which no claim of heredity of the cleft palate could be made. In one of these, however, there was a claim of maternal impression set up, to which no scientific importance can be attached. It, like traumatism in deciding the starting-point of some morbid growth, is a convenient reason, satisfies the popular fondness for mystery, and is, I believe, most frequently an after-thought.

Confident that the subject-matter of this short paper will receive due consideration, the result of the further inquiries can but be watched with much interest.

## SOCIETY TRANSACTIONS.

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### NEW YORK DERMATOLOGICAL SOCIETY.

REPORTED BY DR. E. B. BRONSON, SECRETARY.

*Ninety-fifth Regular Meeting, September 23, 1878.*

DR. F. R. STURGIS, PRESIDENT, IN THE CHAIR.

THE following cases were exhibited before the Society:

#### Pseudo-pigmentary syphiloderm.

DR. BULKLEY presented a syphilitic woman with abnormal pigmentation of the neck, following and due to antecedent specific lesions. The case was presented as an instance of false syphilitic pigmentary disease of the skin to illustrate points of difference between it and the true affection as described by Hardy, Fournier, and others, and as exhibited in the patient whom he had shown at the last meeting of the Society (*ARCHIVES OF DERMATOLOGY*, vol. iv., p. 239). The patient had been syphilitic for two or three years. Upon a simple chloasma occupying the sides of the face and neck there were a number of white, oval or rounded spots with pigmented periphery situated upon the sides of the neck, more especially the left. The skin in these spots was more or less atrophied.

DR. STURGIS remarked that the affection presented was rather an atrophy of the skin than a true pigmentary disease. As to the true pigmentary syphilide, he believed that it must be very rare here; he had never seen a case of it in this country. It was his impression that some English writers had confounded the disease described by Hardy and Fournier with atrophic conditions of the skin, with loss of pigment, occurring usually in the later stages of syphilis.

DR. BULKLEY observed that the pigmentary syphilide was a symptom pertaining to an early stage of syphilis, and would not be found unless looked for at such time. He referred to the frequency of the manifestation as observed in Paris. At a recent visit in that city no less than seven cases of the affection had been pointed out to him by Professor Fournier.

DR. STURGIS showed a case of

### Inherited syphilis

in a female child æt. 2 months, showing a very extensive syphilide of the raised erythematous variety. There were no lesions of the mouth or anus. He commented upon the absence of mucous patches or other lesions about the anus, or about or within the mouth, and inquired whether it had been observed by any one that if when the cutaneous manifestations were well pronounced the mucous membranes were apt to be comparatively exempt from lesions, so as to indicate the existence of a certain correlation between the skin and mucous membrane.

DR. BULKLEY thought that mucous patches did not occur in the mouth till after the roseola. In the present case, therefore, they might still come later. He added in regard to this case that the mother had been under his care a year or so previously with chancre of the breast. An older child about  $1\frac{1}{2}$  years of age was at the time under his treatment for eczema, when one day he presented a large papular syphiloderm, and on inquiry the mother was found to have a chancre of the breast; she soon had a macular eruption of syphilis, but was then lost sight of.

DR. KEYES observed that no certain rules with regard to the development and sequence of the manifestations of syphilis could be depended upon. He thought mouth lesions might occur in the course of the roseola, and even from the very first.

DR. SHERWELL presented a case of

### Eczema papulatum et rubrum

in a laboring man. The disease affected the face (especially the forehead, where it had an erythematous character), the eyelids, the wrists, and the scrotum.

DR. PIFFARD said that in cases where there was an extensive erythematous eczema of the face with much heat, redness, etc., he had had much success with the following course of treatment. He first caused free purgation by means of an infusion of senna and viola tricolor combined, after which the infusion of viola alone was administered at night. It was urged that care be taken to procure viola of good quality. Only the foreign drug was regarded as serviceable. The cultivated plant as found in this country yielded but a small proportion of the active principle, namely, violin, while the imported herb as found in the markets was liable to be old and of poor quality.

DR. BRONSON spoke with regard to the eczema of the scrotum, and recommended for the relief of pruritus in such cases a strong solution of carbolic acid in glycerine. In eczema affecting the scrotum, anus, or vulva he had found this remedy superior to all others for the purpose mentioned. He used it in the strength of a drachm to the ounce, which was often increased to two drachms to the ounce. The solution was painted over the affected parts at night with a brush,

and, if necessary, the application was once repeated, after a short interval, the parts having previously been sponged and dried. Besides this he used simply an emollient powder, plentifully applied.

DR. SHERWELL said that at first he had treated the face with applications of linseed oil, and afterwards with diachylon ointment, but these appeared to have a bad effect. Since then the case had steadily improved under alterative and tonic treatment, combined with an occasional purgative. He was accustomed to use mercury and iodide of potassium in these cases with good effect, due, he believed, to their promoting free glandular action, which was always impaired in these cases.

DR. PIFFARD concurred with Dr. Sherwell, and believed that eczema was often associated with hepatic trouble, which would be benefited by some mercurial or other cholagogue. He particularly commended the use of iris versicolor to this end. He did not think the benefit to the skin was owing simply to the revulsive action of the purgatives, because the improvement was permanent.

DR. MORROW introduced a case of

### **Psoriasis guttata**

of six years' duration in a girl 10 years of age. The back, abdomen, and chest were occupied by an abundant, partly discrete, partly confluent, and somewhat figured eruption. The spots varied in size from that of a pin-head to that of a pea, were red, slightly elevated, and covered by small thin and adherent scales. The spots showed little disposition to bleed when the scales were scraped off. There were some small scaly patches about the knees, none upon the elbows, while other parts of the extremities showed only a few red, not scaly spots. The scalp was free.

DR. SHERWELL remarked that such a case might get well without interference. He had at present under observation three children in one family who had the disease, and were getting well under expectant treatment.

DR. PIFFARD believed that it was possible for the disease to wear itself out. In one instance he had seen the disease disappear and remain absent for six or seven years.

DR. FOX also had seen mild cases recover spontaneously, and though long periods had since elapsed the disease had not yet returned.

DR. BULKLEY suggested the use of chrysophanic acid.

DR. PIFFARD regarded the case as inappropriate for local treatment, and would prefer either simple expectant treatment or else some remedy of a tonic or alterative character.

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*Ninety-sixth Regular Meeting, October 22, 1878.*

The following cases were presented :

DR. ROBINSON introduced a patient with

**Alopecia areata,**

a young man 18 years of age. The disease had been of three years' duration. A large area, occupying the back part of the head, was almost totally devoid of hair, while the growth upon the other portions of the scalp remained normal.

DR. PIFFARD advocated the use of his cosmetics of croton oil. He showed two preparations, one composed of half croton oil and the other half wax; the other of croton oil, wax, and cocoa oil, equal parts.

DR. SHERWELL favored treating the disease by galvanism, the positive pole being applied to the scalp at the point affected, while the negative was held in the patient's hand.

DR. MORROW showed a case of

**Urticaria pigmentosa,**

which had been before the Society one year ago. A full report of this case would be presented by Dr. Morrow at the next meeting, and the discussion thereon was deferred until that time.

DR. FOX presented a case of

**Persistent eczema squamosum**

of the muco-cutaneous surface of the lips, more especially the upper. The disease had been of eight or nine years' duration. It was characterized by desquamation of the epidermis, but with no tendency to fissure. At the border of the mucous membrane of the upper lip numerous yellowish-white specks were scattered over the surface, apparently connected with the follicles.

DR. FOX remarked that it had been subjected to great variety of treatment, extended over a long period. Among the measures employed before the case came into his hands were arsenic internally, and locally, the use of the actual cautery, by means, as patient stated, of a hot awl, which was used to burn out the little whitish spots, which were regarded as deep-seated vesicles. DR. FOX had himself employed a great variety of remedies, both local and general, but, thus far, with indifferent results. As to the whitish spots referred to, though he had at first regarded them as deep-seated vesicles, he now believed they were caused by little accumulations of epithelium in the follicles, but had no necessary connection with the disease.

DR. FOSTER said he would treat the disease by irritant or caustic remedies, such as caustic potash and the like.

DR. SATTERLEE had treated similar cases, but usually affecting the corners of the mouth. He had found both soothing and irritant applications of little or no effect, but had derived much benefit from the use of tar. In his cases he had generally discovered rheumatic tendencies.

DR. BULKLEY advised the use of phosphoric acid, both locally and

internally. His formula was : dilute phosphoric acid, glycerine, and syrup, equal parts, to be applied to the affected surface three times a day, and fifteen to twenty drops of the same solution were to be taken internally three times a day. He had treated some three or four cases of chronic eczema of the mucous surfaces of the lip in this way, and with good results.

DR. SHERWELL mentioned a form of chronic eczema of the vulva to which he believed the present case bore a close analogy, and for which he used frictions with common bar- or yellow-soap. This soap contained, he remarked, a large amount of resin.

DR. KEYES called attention to the patient's general condition, which was manifestly anaemic. He would regard as matters of chief importance hygiene, diet, and general tonic treatment. A good meat diet, with cod-liver oil, and attention to such general measures as might promote health, would furnish the best means of combating the local trouble.

DR. SHERWELL introduced again the lady with

#### **Nævus of the chin and face,**

who had been shown in the Society once before. Since then almost a complete cure had been effected upon the face, through tattooing with carbolic or chromic acids, according to the method already described by Sherwell in this journal (vol. iii. p. 214). The last operation was in May, 1878. A large patch on the cheek had quite disappeared, without leaving a scar. The disease upon the chin had been so modified as to resemble a simple erythema of the part. About the lower lip the purple color still remained, and would be subjected to further operation. The several former operations had been performed at intervals of from two to three months.

DR. PIFFARD related a case of port-wine mark in a child 12 years old, where operations had been followed by the development of keloid, producing a greater disfigurement than the original disease. There were several spots on the face and neck. One was treated according to Squire's method and another by the burning-glass. Keloid followed in both instances, but worse from the burning-glass.

DR. FOSTER presented a case for diagnosis. The patient was a young woman who had an

#### **Erythematous eruption of the face,**

of a doubtful character, concerning which the question of lupus was raised.

DR. BULKLEY would diagnosticate it to be lupus erythematosus.

DR. FOSTER expressed himself as in considerable doubt concerning the nature of the affection. Sometimes it had looked like a seborrhœa, and at others like lupus erythematosus. Other members of the Society declined expressing any opinion without seeing the case by daylight.

DR. BULKLEY exhibited a case of

### Ringworm of the nose

in a little child. The case was shown at the same time with Dr. Foster's case, for the purpose of comparison, inasmuch as the location of the affection in the child was unusual, and bore a certain resemblance to lupus erythematosus. The disease, which was unquestionably ringworm, as evinced by its course and the microscopic examination, occupied the entire surface of the nose, and extended upon the cheeks on either side to the distance of three-quarters of an inch, and down upon the upper lip to near the vermillion border.

DR. BULKLEY being asked with regard to his case of ringworm of the face what his treatment would be, replied, "By sulphurous acid."

DR. FOX thought that, out of respect to the proximity of the olfactory member, hyposulphite of soda and rose-water would be preferable.

DR. FOSTER introduced a case for diagnosis.

### Morphea or scleroderma.

The following history of the case was prepared by a special committee, consisting of Drs. Foster, Piffard, and Bulkley, appointed by the Society to examine the case by daylight. Reported by Dr. Bulkley.

Bessie Lindsey, aged 25, a native of Ireland, has been four years in the United States. She has always enjoyed good health, and has never had any eruptions or disease on the skin previous to the one under consideration.

The affected leg was perfectly healthy three years ago. In the spring of 1876 she first noticed a red spot appearing about the middle of the calf of the right leg, posteriorly. The disease has remained until the present time, steadily increasing, and at no time has it been greater than at present. The present appearances may be thus described :

The location of the disease is on the outer and posterior aspect of the right leg, touching the median line at three points, but not traversing it, except to a slight extent just below the popliteal space. It extends from the external malleolus to the popliteal space, and reaches on to the posterior aspect of the thigh for three or four inches, but in a much less fully developed form ; the outline of diseased surface is irregular, it being two and a half inches wide at the widest portion, at about the junction of the upper and middle thirds of the leg, and an inch and a half in width at the narrowest portion, near the ankle. At no point is the margin in a straight line, but the entire disease is made up of apparently separate patches fused together, their general course being, however, in a line from the external malleolus to the popliteal space, extending to a length of ten and a half inches on the leg, and between three and four inches on the thigh.

She states that the first appearance of disease in every instance is

in the form of a reddish spot, similar to one which exists on the instep, just in front of the external malleolus. Certain other portions of the disease, as on the thigh, where the disease is still progressing upwards, present also the same erythematous stage.

The surface where the disease has undergone its fullest development is of a dirty tawny-white, somewhat resembling old ivory, and on some portions there are quite an appreciable quantity of firmly-adherent scales.

The margins of by far the larger portion of the yellowish patches are surrounded by a lilac, purplish, or weak-claret colored border, erythematous in character, sharply defined at the margin of the patches, and shading insensibly into the color of the healthy skin externally; the spots which are not fully developed on the ankle and thigh present the same color and character.

The margins of the diseased patches can be very clearly made out with the ends of the fingers, and most of the fully-formed disease can be mapped out by palpation, with the eyes shut. The fully-affected portions have a hard, boiled-shoe-leather, or rind-of-bacon feel, and the surface cannot be pinched up from the underlying tissues, as can healthy skin; but there is no appreciable contraction of any part. In some parts there is apparent depression of surface, in others a slight apparent elevation.

DR. FOX spoke of the uncertainty that existed with regard to the relations to each other of morphea and scleroderma. He had seen three cases which he believed to have been morphea, and which in many respects bore a very marked resemblance to the case presented. In all of them there was the same glossy, corneous aspect of the skin exhibited by the present case, together with the same hide-bound condition. They all apparently tend to follow the course of a nerve. He should regard the case as morphea.

DR. ROBINSON thought it morphea.

DR. PIFFARD believed it to be a typical case of scleroderma. In this disease the process began with a hyperplasia, followed by atrophy. At first the interspaces in the cellular tissue were packed with cells, and this stage was marked by more or less elevation of the surface. The cellular growth by pressure caused atrophy of the fibres, with consequent contraction. In the present case such a course was in progress. In a year he believed the case would show a perfectly white, contracted surface.

DR. BULKLEY differed from Dr. Piffard in his diagnosis of the case, and would regard this as a well-marked example of what had been described by Wilson, Duhring, and himself as morphea. He had seen six or eight cases of scleroderma, and four cases of morphea. He had seen localized cases of both diseases. The distinguishing marks between the two were the well-defined margin of the disease which existed in morphea and not in scleroderma, and the strong tendency to contraction which characterized scleroderma, and was not seen in morphea, it being strikingly absent in this case. He called attention to the ease with which the disease could be mapped

out in the present case by the sense of touch alone as well as by its lilac border. This lilac border was not a mark of scleroderma, the limits of which were indefinite and vague. There was not the dense hardness and hide-bound character of scleroderma. To a question from Dr. Piffard with regard to Hilton Fagge's cases of morphœa, Dr. Bulkley replied that they all represented only one form of the affection. In all the disease occurred in isolated raised patches upon the face.

DR. CAMPBELL thought it was morphœa.

DR. WEISSE also believed the case to be morphœa. In scleroderma there was not the well-defined, pigmented edge exhibited in this case. The disease seemed to follow the course of the external saphenous nerve. He believed that on close examination the sensibility and temperature would be found lowered.

DR. SHERWELL would regard the case as scleroderma.

DR. PIFFARD thought the case was identical with the morphœa of Hilton Fagge. As to the border of the affected part, he remarked that there was always a sensible edge to atropic spots in the skin, and this would become more marked as the disease progressed.

DR. BULKLEY explained that by the border in this case he did not refer to the edge of a depressed portion of the surface, such as would be presented by an atrophied and shrunken patch of skin, but a distinct line of infiltration, easily traced by the sense of touch alone.

DR. FOSTER was inclined to believe that the case bore many of the features of the xeroderma of Hebra.

DR. BRONSON exhibited a case of

#### **Eczema universale**

in an old man. The disease had existed since the early part of spring. It began as an eczema of the nates, which shortly spread over the entire body, head, and extremities. Its progress was very rapid. The skin was everywhere of a vivid red, and, with the exception of a few moist patches on the neck and head, was freely desquamating.

DR. SHERWELL showed a case of eczema intertrigo.

DR. BULKLEY presented a patient with a peculiar condition, which he called

#### **Chronic recurrent erythema of the hands.**

Patient was a man 35 years of age, and had been subject to the disease for eight years. It was situated upon the backs of both hands, near the roots of the fingers. There was also something of the same towards the wrists. The redness had not been preceded by any other eruption. It passed away in winter and returned in summer. There was no sensation of itching. Near the roots of the fingers were some pale superficial scars.

DR. KEYES showed a case of

#### **Favus**

of the scalp in a child, showing very rapid improvement under the use of an ointment of impure chrysophanic acid.

## DIGEST OF LITERATURE.

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### I.

#### DISEASES OF THE SKIN.

##### ANATOMY, PHYSIOLOGY, AND PATHOLOGY.

A. R. ROBINSON, M.D.

**Histological researches on the normal anatomy of the human skin.**—Dr. REMY finds in a human embryo of two centimetres some points of epithelial resemblance with a chick embryo of three days. A deep layer is formed of cells whose walls are very thin, ill-defined, and almost filled by a nucleus. A superficial layer is formed of flat cells with a flattened nucleus. At this age the deep layer takes the rôle of generator and reproducer, and retains it during the whole of the life of the individual. In an embryo of ten centimetres, the epidermis has increased in thickness and extent. There still exists no prolongation for the papillæ, but the matrix of the nail is indicated by a fold of epidermis. At this period the epidermis has three distinct layers,—the generating layer already described, the Malpighian layer, and the external layer, which will form the corneous layers.

Towards the fourth month the papillæ and the annexes of the epidermis appear. It is the external layer which forces itself into the cutis, while the epithelial prolongations are formed at the expense of the generating layer. At this period the corneous layer is composed of two rows of cells; the Malpighian layer is unchanged. From the generating layer are formed the annexes of the epidermis as well as the interpapillary prolongations.

In the formation of the sweat-glands the epidermic prolongations pass perpendicularly downward in the cutis, and after an unequal course enlarge to a club-shape. The gland is at this period solid, and becomes hollowed out towards the seventh month of intra-uterine life. At the same time it elongates, curves in the form of a cross, and on this cross the flexures appear which constitute the definite gland.

The sebaceous glands and hair-follicles are formed from the same layer as the sweat-glands, and differ but slightly in the mode of their formation.—*Gazette Méd. de Paris*, May 4, 1878.

**The origin of the cell nucleus.**—According to STRICKER the nucleus of the white blood-corpuscles of the triton is nothing else than an enclosed part of the movable cell-body,—a part, however, which can again become free from its fetters by tearing, or by

division of the capsule. The free nucleus also, with its movable internal structure, is nothing but an enclosed cell-body. This capsule contains openings, or is permeable, so that the enclosed organism can send prolongations outwards, and the outer cell-body can draw within the capsule. In the completely-enclosed condition many cell-bodies appear to solidify, and also the movements within the capsule to cease. In this manner the free nuclei of the older authors is produced. According to these observations of Stricker the nucleus of the actively-movable, fresh, colorless corpuscles of the frog and triton are not persistent, formed elements. They are temporary, enclosed portions of the cell-bodies. The capsule itself, however, is nothing but cell-body, a zone of the cell-body in a certain chemical condition different from the rest of the cell.—*Med. Jahrbücher*, Heft I., 1878.

**On the action of the nervous system on the sudoriparous glands.**—VULPIAN, from experiments, says we can prove that all the excito-sudorific fibres contained in the sciatic nerve do not come from the spinal cord through the intervention of the abdominal sympathetic cords, and says it can be proven that a great number of those fibres, after having taken origin in the spinal cord, are conducted to the sciatic nerve by the roots of those nerves. On the other hand, experience tends to show that there is in the abdominal sympathetic cords moderating fibres which, acting in a certain manner, control the actions of the sudoriparous glands.—*Gazette Méd. de Paris*, June 8, 1878.

**The secretion of sweat.**—Dr. ADAM KIEWICZ galvanized various motor nerves in man, and, as a result, sweat-drops appeared at once upon the corresponding portion of skin and upon a symmetrical spot on the opposite side of the body. The perspiration is independent of the circulation, and can be induced by direct galvanization of the muscles, as well as by their voluntary contraction.

In cats, the paw will sweat on stimulating the sciatic nerve, even after death or removal of the member.

As regards the sweat-centres in the cord, he found that perspiration of the hind paws can continue after division of the spinal cord at the level of the first lumbar vertebra. On shortening the lumbar cord by successive slices, the spinal centres of the sweat-nerves of the hind paws were found to be situated in the portion between the first and fourth lumbar vertebrae. After removal of the lumbar fragment of the cord, stimulation of the brachial plexus produces sweating of the hind paws, owing to the connecting fibres which pass from the sympathetic to the sciatic nerve.

Finally, it was shown that the common centre of all sweat-nerves is in the medulla oblongata. Berlin, 1878.—*Journal of Mental and Nervous Diseases*, July, 1878.

**Dysidrosis.**—Dr. TILBURY FOX describes the appearances he believes to have seen in sections made from a portion of skin

affected with "dysidrosis." According to his interpretation, there is dilatation of the sweat-ducts, producing vesicles in the mucous layer of the skin. Whether the sweat-duct coil was affected or not, he is not prepared to state.

[This question was pretty thoroughly discussed last year, when we endeavored to show that the vesicles are formed of serum which comes from the blood-vessels of the underlying papillæ. In our case there was no dilatation of the sweat-ducts or disease of the sweat-glands, and the only question which remained to be decided was as to the case being one of "dysidrosis" or chiero-pompholyx. As previously stated in the ARCHIVES (vol. iii. p. 289), the patient was seen by other dermatologists here, and by Dr. Duhring, of Philadelphia, and the diagnosis was accepted as the correct one. Since then we have shown the patient to Dr. C. Heitzman, and he also examined some of the sections, including Fig. 1 of our article on pompholyx, and he unhesitatingly agreed with our opinion of the case, believing it to be somewhat related to herpes, perhaps, and was certainly neither pemphigus or "pemphigoid in character." We do not believe it possible for vesicles to be formed by any sweat-duct or gland derangement, and have the clinical history of the vesicles of "dysidrosis." The duration of the period of formation of the vesicles, their mode of arrangement in groups, their deep seat, the albuminous nature of their contents, and the tendency to recurrence of the disease show, we believe, that the disease cannot be an affection of the sweat apparatus. We will, however, discuss the question in full in connection with diseases of the sweat-glands at a future period, when we will give our arguments at greater length.]

As regards Dr. Fox's sections, we will here remark that his description of their appearance does not appear to us to be a very correct one. His sections evidently coincide very closely with our own, and we believe he has erred (quite unintentionally) in the interpretation to be given them. *We also* have seen sweat-ducts at the base of a vesicle, but close examination of several adjoining sections showed us that the duct never entered a vesicle, but passed along its margin, being pressed aside by the accumulating serum forming the vesicle contents. Vesicles from sweat were often found in the corneous layer; but the contents were not serum, and contained no round cells, as in the case of the deep-seated sago-grain vesicles. Whilst, however, we disagree with Dr. Fox in his interpretation of the appearances presented by the sections, we admit that whatever his sections actually show, *that* must be accepted as the nature of his "dysidrosis," as we would not think of disputing his diagnosis. If therefore Dr. Fox will allow gentlemen well known as competent microscopists, and accustomed to microscopical examinations of the skin, to examine his sections, and if they agree with him as to the nature of the disease, then it seems to us that the question is settled. Without stating our reasons or desiring to be personal in our remarks, we must say that we are not prepared to accept without re-

serve Dr. Fox's microscopical work in this case. If he had shown the sections to such a microscopist as Dr. Thin, and the latter gentleman, after thorough examination, would say that the vesicles are undoubtedly formed by a dilatation of the sweat-ducts, then I would be prepared to accept the sweat-duct theory. I say *undoubtedly* formed by the sweat-ducts, as it is not one of the simplest tasks in microscopy to tell whether a vesicle is formed from a sweat-duct or not.—REP.]—*British Med. Journal*, May 25, 1878.

**Special alteration of epidermic cells in venereal vegetations.**—Dr. LELORI describes certain changes which he has observed as taking place in the epidermic cells of the intermediary and Malpighian layers of the skin in venereal vegetations. The alteration consists in the formation of a clear, colorless space, separating the nucleus from the cell-body. The nucleus is also more or less changed in size and shape. The author thinks the lesion could be regarded as a special dropsy of the epidermic cell.

[We are inclined to regard the condition as one produced by the mode of preparation of the specimen; at least, we have never observed those changes when treating similarly-affected portions of skin with Müller's liquid.—REP.]

**The pathological anatomy of mucous patches on the tonsils.**—Dr. CORNIL gives the results of the examination of mucous patches which he removed from patients under his care at the Lourcine Hospital.

In an opaline mucous patch the epithelium is thickened and the papillæ hypertrophied, and the deep connective tissue thickened by infiltration of new cells. In the superficial epithelial layer the cells have a cavity around their nucleus; in some instances one or two pus-cells are found in the cavity instead of a nucleus. In this layer there are also little nests filled with pus-cells,—little abscesses hollowed out among the epithelium-cells, and containing from four to one hundred, and even more, pus-cells. It is these little abscesses which give the opalescent appearance to the part.

In the ulcerated variety, the epithelium is destroyed by the quantity of liquid and pus coming from the papillæ. The epithelial layer can be completely destroyed, and then the inflamed papillary body forms the base of the ulceration. There exists sometimes a true false membrane—gray, adherent, diphtheritic—on this ulceration. The false membrane contains no parasites, but the branching state of the epithelial elements, the holes and cavities pierced in them and filled with pus, present the same aspect as in diphtheria. The syphilitic tonsils in the second stage represent a papule upon a syphilitic gland.—*La France Médicale*, Aug. 10, 1878.

**The anatomical alterations of the lymphatic glands in syphilis, scrofula, etc.**—According to CORNIL, in acute adenitis consecutive to a phlegmon or an inflammatory oedema, the afferent lymphatic vessels, the sinuses, lymphatic tracts, and the cavernous

tissue of the ganglion are filled with pus, the cellular adipose tissue which surrounds the capsule is infiltrated with pus, the fat-vessels are surrounded with pus or replaced by a small collection of those cells.

In adenitis of the primary and secondary period of syphilis there is tumefaction, proliferation of the nuclei of the cells of the sinus, and at the same time a slight sclerosis or thickening of the connective tissue. The endothelial cells and the cells of the external membrane of the vessels are swollen, and their ovoid nuclei very voluminous.

In the tertiary period of syphilis the glands can be indurated, cirrhotic, sclerosed, or caseous in places. There is a catarrhal inflammation of all the lymphatic tracts contained in the glands.—*Journal de l'Anat. et de la Phys.*, No. 3, 1878.

**The pathological anatomy of scorbutus.**—According to USKOW, scorbutus is a general disease with characteristic anatomical changes. These characteristic changes can lie in the whole vascular system, but are most general in the gums. In the gums the disease begins in the deep layers, and consists in obstructions in the blood-vessels. The blood-vessels of the papillæ are often so filled, that of the papule almost only the epithelium remains.

The appearances in the deeper layers of the gums are :

a. More or less swelling of the endothelium of the capillaries and small arteries.

b. Later occurs an extravasation of red corpuscles without rupture of the vessels.

c. On the place of collection of white blood-corpuscles the endothelium swells so much that it often cannot be distinguished from the white corpuscles.

d. Proliferation he has not seen ; but later are seen nests of round cells between the connective-tissue bundles. The bundles themselves are not changed.

e. The round cells show no signs of fatty degeneration.

In the most severe cases the papillæ become gangrenous, and later, also, the granulation cells. The disease often passes to the deep layers of the periosteum, between which and the bone are traces of blood-extravasation and caries. Similar changes can occur on the ribs, producing destruction of the bone.—*Centralblatt f. d. Med. Wissen.*, July 13, 1878.

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## INFLAMMATIONS: ACUTE AND NON-CONTAGIOUS.

JAMES C. WHITE, M.D.

**Anatomy of erythema exudativum.**—CAMPANA has observed histological changes in erythema which lead to the following conclusions: The lymph-elements and the plasma escape from the vessels, distend the interspaces of the fibrous tissue, and seek to gain the free surface of the skin. In this way they push before them the epithelial cells, separate and distort them. He regards the process as an exudation, which begins with a disturbance of the circulation, and by means of perivascular and perifollicular infiltration, lymph-oedema of the lacunæ and interciliary spaces, produces the development of papules, vesicles, and diffused infiltration. He considers rheumatism to be the cause of the affection, an hypothesis supported, he thinks, by the anatomical relations of the fibrous tissue and serous membranes.—*Viertelj. für Derm. und Syph.*, 1878; from *Movim. Med. Chirurg. Arch.*, ix., Nos. 28, 29.

**Erythema exudativum multiforme.**—LEWIN, in an article on this affection, mentions among the exciting causes, through reflex influence, disturbances of the uro-genital system. In forty-six of the cases cited in his paper affecting women, ten were suffering from urethritis with uterine disease, and it was proved by experiment that a recurrence might be excited after recovery by mechanical and chemical irritation of the urethra.—*Charité Annal.*, Bd. iii. p. 622.

**Erythema pellagrosum.**—BOUCHARD states that he has determined that the violet portion of the spectrum is most active in producing erythema in pellagra. The forearm of a patient affected with this disease was covered with a fenestrated bandage. One-half of the opening was then covered with a thin layer of sulphate of quinine, and the skin exposed to the rays of the sun. At the end of an hour and a half an erythema was developed upon the naked portion, but not upon that covered with the quinine sulphate. Whether this result was in consequence of the fluorescence of this salt Bouchard does not venture to decide. Charcot found that the

chemical rays are capable of causing more violent erythema than the heat rays. The violet portion of the spectrum has also been shown by Bert to be more active upon the skin of the chameleon.—*Progr. Méd.*, No. 21, 1877, and *Vierteljahr. für Derm. und Syph.*, V. Jahrg. 2 Heft.

**Urticaria with albuminuria.**—Professor LEUBE reports two cases of urticaria in which albumen was present in the urine during the outbreak of the efflorescence. The first patient was under treatment for acute articular rheumatism. Soon after the administration of an excessively-large dose of salicylic acid, intense itching of the skin came on, with redness and swelling of the face and extremities, and well-developed wheals appeared on some parts. This condition of the skin lasted nearly twenty-four hours, and the urine passed during the first of the attack contained a considerable quantity of albumen. On the fourth day subsequently the patient, in consequence of pain in the joints, took the same dose (4.0) of salicylate of soda. Within twenty minutes he experienced burning pain in the skin of the forehead, oedema and redness of the eyelids, and itching of the hand. The lip became greatly swollen, and the whole abdominal integument covered with wheals. In half an hour afterwards nearly the whole surface of the body was similarly affected. The urine, however, was entirely free from albumen. The other case was unaccompanied by complications. A soldier was received into the Erlangen hospital with an ordinary acute, general urticarial efflorescence, without constitutional disturbance. The urine was found to contain a not inconsiderable amount of albumen, which condition persisted nearly twenty-four hours. [Of course the reporter suggests the temptation of explaining these occurrences by vaso-motor disturbances, but honestly confesses that we know too little about such matters to warrant any such conclusion. The first case may have been caused by the salicylic acid, which is known to have produced the disease in many instances.—REP.].—*Allgem. Med. Central-Zeitung*, June 5, 1878.

**Is urticaria caused by sulphate of cinchonidia?**—Dr. KEMPER, of Muncie, Ind., states that he and his partner have frequently remarked upon the unusual number of cases of urticaria which have occurred this season, especially among children attacked with malarial fevers. During this time they have used the sulphate of cinchonidia almost wholly in place of quinine; and families keep and use the former. By such persons they have been quite commonly consulted for "hives" and "nettle-rash," which occur early in some cases, later in others. In many instances, instead of the ordinary form there was marked puffiness of the face, eyelids, and sometimes of the extremities. In one case the eyes were nearly closed by the swollen lids. The cinchonidia was left off, and the swelling disappeared. Two weeks afterwards, when a few doses had been taken, the swelling reappeared. Dr. K. states that to a patient in whom quinine had several times produced an erythema of

marked degree, he gave six grains of the cinchonidia. At his next visit she, with a reddened face, accused him of having given her quinine again. She gradually became completely covered with an erythematous blush, and subsequently underwent general desquamation. He was formerly disposed to believe that malaria caused urticaria, but has now abandoned that idea.—*The Cincinnati Lancet and Clinic*, Oct. 19, 1878, p. 285.

**Inoculability of erysipelas.**—TILLMAUS, in a communication to the Congress of the German Surgical Society at Berlin, reported the results of his experiments upon this point with forty dogs and rabbits. He employed injections and inoculations with the contents of vesicles in acute erysipelas and the pus from the abscesses of later stages, but succeeded only in two instances in producing a wandering form of the disease upon the animals. Subsequent inoculation of their blood produced in one case an attack of brief duration. The injection of abscess pus or putrid fluids did not cause erysipelas. He could find no bacteria in the affected portions of integument.—*Med.-Chir. Rundschau*, July, 1878.

**Treatment of erysipelas by injections of carbolic acid.**—Dr. HUETER contributes the experience of the Greifswald hospital to this question. A solution of carbolic acid in alcohol and water is injected by the Pravaz syringe into the affected skin at points sufficiently near to each other to control the inflammation. In many cases two or three injections are sufficient; in severe ones five are generally found to suffice; while in the worst as many as twelve have been used. After making them the skin is kept covered with a carbolized compress, which is changed two or three times a day. If the erysipelas is accompanied by lymphangitis and lymphadenitis, mercurial ointment is spread thickly along the course of the red streaks and over the swollen glands.—*Berliner Klinische Wochenschrift*, June 17, 1878.

**Occurrence of herpes during the administration of arsenic.**—Dr. FINLAYSON, of Glasgow, reports, in confirmation of the opinion expressed by Hutchinson that zoster is frequently developed during the use of arsenic, two cases in which this affection occurred in young women while under the action of the drug. [Observations of such occurrence are not yet numerous enough to warrant the positive conclusion that the alleged connection is more than accidental. Zoster occurs during the use of other drugs. For instance, we have under observation at this time a fully-developed case upon the *thorax* in a syphilitic patient under treatment by mercurial inunction.—REP.]—*The Hospital Gazette*, Aug. 8, from *The Practitioner*, July, 1878, p. 18.

**Herpes zoster.**—Dr. WALTHER, of Mittweida, reports the following singular occurrence of zoster. A student affected with the disease removed from his room. The next occupant shortly after

was attacked with the same affection. This one also removed, and the third occupant, also a student, was immediately attacked with the same disease.—*Allgem. Med. Central-Zeitung*, April 24, 1878.

**Hydroa and bullous eruptions.**—Under this title Dr. FOX, of New York, reports a case of acute vesiculo-bullous eruption, and takes the opportunity of discussing the relations of bullous efflorescence of varying degrees of severity to true pemphigus. He advocates the adoption of the French term hydroa to indicate certain cases of vesiculo-bullous eruptions which are neither herpes nor pemphigus.—*Archives of Dermatology*, July, 1878.

**Acute pemphigus.**—Dr. ADLER reports a fatal case of this rare affection. After brief prodromal symptoms, the patient, a woman, 48 years old, and an inmate of an insane asylum, exhibited upon the feet and lower legs an eruption of small bullæ, which on the following day spread upwards upon the trunk. She complained of severe pains in the limbs, thirst, and weakness, and died three days after the first manifestations upon the skin. After death the mucous membrane of the oesophagus and pharynx was found reddened and deprived of epithelium in spots.—*Berliner Klinisch. Wochenschr.*, Sept. 16, 1878, p. 553.

**Fatal action of burns.**—SONNENBURG attributes the cause of death in rapidly-fatal cases of burns either to the overheating of the blood and the cardiac paralysis which necessarily follows upon this, or, especially in cases of less rapid death, to collapse in consequence of excessive irritation upon the nervous system, which is followed by a reflex action upon the vessels. He gives details of his experiments upon animals by which he reaches these conclusions.—*Viertelj. für Derm. und Syph.*, v. Jahrg. 2 Heft, from *Deutsche Zeitschr. für Chir.*, ix., p. 138.

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## INFLAMMATIONS: CHRONIC; SQUAMOUS, PRUGINOUS, AND PUSTULAR.

W. T. ALEXANDER, M.D.

**On psoriasis universalis.**—Dr. KAPOSI reports gratifying results of treatment by inunctions of cod-liver oil, baths, and enveloping the affected parts in rubber cloths. He has seen annoying eczema follow the use of inunctions, which was relieved by continuous baths and the application of unguentum diachyli.—*Wien. Med. Wochenschr.*, 1877, Nos. 44, 45.

**On the nature and pathological histology of psoriasis.**—Dr. A. R. ROBINSON, in a carefully-written paper, details the results of his microscopical researches into the changes occurring in psoriasis. He finds that they consist in a hyperplasia of the Malpighian layer, with a slight increase in size of the inter-Malpighian spaces, due to dilatation of the blood-vessels, transudation of the serum, and the presence of out-wandered, colorless blood-corpuscles. In small papules, the horny layer of the epidermis was but little if at all thickened. The increase in thickness of the rete Malpighii he believes to be due to the increase in number of the normal cells composing it. He noticed an apparent increase in the size of the papillæ, which he shows to be due to the growth downwards of the rete, and not to changes taking place in the normal papillæ.—*New York Med. Journal*, July, 1878.

**Illustrations of a novel and successful treatment of psoriasis.**—Dr. JAMES ADAMS reports six cases cured by chrysophanic acid ointment, in an average period of four weeks. He also made trial of a watery paste of alizarine, which arrested impending relapses in two of the cases. Alizarine is a product of coal-tar, isomeric with chrysophanic acid, and much cheaper.—*Edinburgh Med. Journ.*, July, 1878.

**Treatment of two cases of psoriasis by immersion and chrysophanic acid.**—In one of these cases of SQUIRE's the tepid bath ( $90^{\circ}$ ) was used for five hours daily during a period of six weeks, at the end of which time the eruption had nearly disappeared, and was completely removed in ten days more by chrysophanic acid. In the discussion which followed the report of the cases Dr. Ford said that he thought the staining of the clothing was the worst objection to the remedy. Mr. Hutchinson regarded chrysophanic acid as no better than some other drugs in psoriasis. Mr. Crocker had been compelled to abandon its use on account of the staining. Mr. Squire said that the hair of the patient would not be stained unless soap and water were used.—*London Clinical Society, Lancet*, Feb. 16, 1878.

**Contributions to the etiology and therapeutics of psoriasis vulgaris.**—After having studied in different countries three hundred and twenty-seven cases of the disease, Dr. E. POOR has convinced himself that psoriasis is never a purely local disease, and is inclined to believe that it is nothing more than an expression on the skin of malarial poisoning. His reasons are as follows: the disease occurs principally in regions in which chronic intermittent fevers are endemic; it appears usually in the spring and autumn; is generally accompanied by the visceral symptoms of chronic intermittent fever; the pathologico-anatomical changes are almost the same in both; and, finally, the most satisfactory treatment of psoriasis and scaly diseases of the skin is the same as that of chronic intermittent. He cites authorities to show that there is a connection between psoriasis and rheumatism, neuralgia, gastralgia, and cardiac diseases, and that it often appears vicariously with these diseases.

Poor believes that the frequent relapses of psoriasis are due to the fact that it is treated as a purely local disease. He explains the temporary cure of psoriasis by the local use of tar, carbolic acid, etc., by the supposition that these remedies are absorbed and act upon the cause of the disease. He maintains that, in order to prevent relapses, measures must be taken to cure the malarial cachexia. A number of cases are detailed in the paper, which closes by proposing the term "psoriasis malarica" or "hepatica," and maintaining that psoriasis bears the same relation to malaria that psoriasis syphilitica does to syphilis.

[The value of the author's opinion is considerably lessened by the admission that he is unable to state whether relapses occurred in his cases or not.—REP.]—*Prag. Vierteljahrsschrift für Pract. Med.*, 1878, vol. iii.

**Arthritic psoriasis.**—Dr. FERRIER reports the case of a man of phthisical parentage, who was attacked, at the age of 27, by psoriasis, which became general. It yielded to treatment, but reappeared in two months, when the patient was suffering from rheumatism. During the remaining fourteen years of the patient's life both diseases became much worse, the rheumatism resulting in complete ankylosis of all the articulations, except those of the shoulders, elbows, the thumbs, and the sterno-clavicular, these being only partially fixed. The psoriasis became and remained general. The skin was not covered with scales, but with a dry, earthy-like powder. The nails were so much thickened that they were almost cylindrical in shape, of a yellowish color, and so much bent over that they touched the palmar aspect of the fingers. The patient died of inanition. The autopsy showed the lungs normal, some vegetations on the mitral valves, firm adhesions of the lungs and liver to the diaphragm, and the intestines closely matted together. In the joints the lesions of chronic rheumatism were found. The striking peculiarity of the case was that the rheuma-

tism affected the joints around which the psoriasis developed, and followed exactly the march of the cutaneous disease. Ferrier regards this case as one offering striking proof that the psoriasis was due to general diathetic influence; that it was symptomatic of the arthritis.—*Le Progrès Méd.*, Oct. 5, 1878.

**The treatment of psoriasis by arsenic in large doses.**—L. SHAFTER reports five cases which had resisted all ordinary specific lines of treatment, but yielded to arsenious acid given in very large doses, as high as one-fourth to one-half a grain. He prefers to give the acid in solution, or in pill, with bread crumb.—*Lancet*, Oct. 5, 1878, p. 474.

**Contribution to the study of the etiology of psoriasis vulgaris.**—Dr. I. NEUMANN cites cases which prove that, where there is a predisposition to psoriasis, local irritation causes an outbreak of the disease on the irritated spots. The disease does not remain limited, but spreads. Long-continued use of fomentations or lotions also may cause an appearance of the disease in psoriatic persons. He has seen the use of the sharp spoon followed by a fresh attack.—*Allg. Wiener Med. Zeit.*, Aug. 26, 1878.

**On the influence of chrysophanic acid in psoriasis vulgaris, chloasma uterinum, pityriasis versicolor, and other diseases of the skin.**—NEUMANN regards chrysophanic acid as an admirable remedy for pityriasis versicolor, eczema marginatum, herpes tonsurans, lupus erythematosus, and cutaneous syphilis. In eczema he has had only bad results from the drug, even when a very weak ointment was used. This was also the case with sycosis of the upper lip.—*Wiener Med. Presse*, Sept. 15, 22, 29, 1878, Oct. 6, 1878.

**An attempt to explain the nature of psoriasis by a study of its clinical characteristics.**—Dr. E. LANG having formed a theory that psoriasis was due to the presence of a fungus in the skin, attempts to prove its correctness by an analysis of the clinical peculiarities of the disease. He first describes the dermatomycoses as local affections of parasitic origin. If the growth of the fungi be slow, they may remain in one spot for years. If several spots are near together, they usually coalesce and form a connected group of permanent colonies of fungi. But in many instances the nutritive changes in the fungi are very active, the supply of nutriment soon becomes exhausted, and the parasites can live only by spreading peripherically. The exhaustion of the supply of nutriment continues for a time, during which no new formation of fungi occurs in such spots. Such colonies spread in the form of constantly-enlarging rings, the centres of which have acquired a temporary immunity by the exhaustion of nutritive material. When two such rings come into contact, the two contiguous portions die out on reaching those portions of the skin which have ceased to furnish food for the parasite. Colonies of fungi also appear *de novo*,

and the disease of the skin presents itself in the form of points, round spots, large continuous surfaces, rings, and gyri. These lesions are always sharply defined. They are common to psoriasis and the dermatomycoses. In all the principal seat of the disease is in the cellular strata of the skin. Despite the irritative phenomena which arise, psoriasis may be regarded as attacking principally the epithelial layer of the skin, a fact which explains the healing without scarring or pigmentation of this disease. The palms of the hands are but seldom attacked by psoriasis, which is also the case with the dermatomycoses. Neither spreads to the mucous membranes. In neither are affections of internal organs to be regarded as causes of the disease. Psoriasis frequently disappears if the patient is attacked by another affection, which may be due to the fact that the fungus can live on well-nourished skins only.—*Vierteljahresschrift f. Dermat. und Syphil.*, 1878, Heft 3, p. 433.

**Enfoliative dermatitis of children at the breast.**—RITTER VON RITTERSHAM. The mortality of the disease is about 50 per cent. It makes its appearance from the second to the fifth week of life, in the following order: Dryness and slight desquamation, redness of the lower part of the face, with fissures at the angles of the mouth, the mucous membrane of the latter becoming hyperæmic, and the seat of large, irregular erosions, covered with a thin, grayish layer. Meanwhile the child remains well nourished, and shows no elevation of temperature. Later the redness extends over the whole body, and crusts form on the lower part of the face, under which the skin becomes deeply fissured. The epidermis over the whole body is thickened, and lifted up from the cutis by a thin layer of fluid exudation. The epidermis is soon thrown off in large masses, leaving the exposed cutis of a dark-red color, presenting an appearance like that of an extensive burn. Sometimes a thin, yellowish crust forms on the exposed cutis, which becomes dry and firmly adherent, especially at its edges. The hands and feet are particularly affected, and the epidermis peels off in great flakes. Several varieties of the affection in its early stages were observed, sometimes thickly-scattered miliary vesicles being seen, principally seated on the forehead extending to the scalp. In other cases the eruption resembled an eczema. In a third class of cases, the epidermis was elevated in the form of vesicles and bullæ, resembling closely those of pemphigus. Desiccation occurred rapidly, so that the appearance of normal skin was again presented in twenty-four to thirty-six hours. In exceptional cases, the skin presented a remarkable dryness throughout the whole course of the disease. In these no large masses of epidermis were thrown off, but the skin became fissured and presented a parchment-like dryness. The portions of skin affected were limited in extent, and exhibited here and there thin and firmly-adherent crusts. Regeneration of the epidermis took place more slowly than in the other class of cases. This type of the disease occurred in children whose nutrition had suffered from other causes. All of

these changes usually took place within a week. Later a slight desquamation occurred, often accompanied by eczema, furunculosis, and formation of abscesses in the cellular tissue, sometimes resulting in extensive phlegmonous infiltration, gangrene, and death, from intercurrent pneumonia, colliquative diarrhoea, etc. The author regards the disease as of a pyæmic nature. It is not contagious.—*Centralzeit. f. Kinderheilk.*, Oct. 1, 1878, p. 3.

**Colored exudates in eczema.**—W. L. LINDSAY reports a case of chronic eczema of the leg, characterized by discharges which imparted a bluish, greenish, or yellow color to the dressings applied. He raises the question whether the morbid mental condition of the patient (imbecility with intercurrent attacks of mania) may not have been instrumental in causing this phenomenon. (He had first satisfied himself that it was not due to the remedies used, nor to malingering.) Dr. Ritchie suggested that it might be due to the presence of indican, formed in consequence of defective renal elimination.—*Medical Times and Gazette*, March 9, 1878.

DR. S. MACKENZIE in a letter to the same journal (March 30, 1878), reports a case of parenchymatous nephritis with extreme anasarca, in which the fluid that drained away from punctures made into the legs imparted a green or greenish-blue color to the dressings.

**On eczema.**—RIEMER reports the results of histological investigations of the skin in a case of chronic eczema occurring in an old woman. The papillary body was hypertrophied, and the rete Malpighii showed a diminution in the number of its cell-layers. The most striking changes were found in the scalp, where, although the hairs were still in good condition, almost no traces of sebaceous glands could be found.—*Archiv für Heilkunde*, 1878, vol. iii.

**The local treatment of eczema.**—Dr. H. G. PIFFARD regards the internal treatment of eczema as of more importance than the local, but considers the latter as of great value. He deprecates routine treatment, and insists on the necessity of a clear comprehension of the special indications presented in each case. He analyzes the disease clinically from the prodromal congestion through its development into the special primary lesions of the disease. In the first stage the congestion should be reduced by astringents, and the itching relieved by anti-pruritics. For the latter purpose he specially recommends the mixture of equal parts of camphor and chloral hydrate, in the proportion of ten to twenty grains to the ounce of ointment. [This combination he attributes to Dr. Anderson, of Glasgow, but we believe that Dr. Bulkley was the first to propose it, in 1874.—REP.] In the second stage of the disease, that of exudation and crusting, he recommends the avoidance of water, and the washing of the parts in a mixture of rose-water with a little glycerine and chloride of sodium. To heal the diseased skin after removal of crusts, he uses zinc, mercurial, and lead ointments. He has found the tincture of Hamamelis Virginica of great service to relieve the itching in this stage. In the period of redness, dryness,

and scaling, tar is the best remedy. In chronic eczema he has found good results from the hypodermic injection of the arseniate of sodium into the diseased patches. For the removal of excessive infiltration he recommends the use of strong alkaline lotions, galvanism, or ointments made from the tinctures of hydrastis or iris versicolor.—*New York Medical Record*, Oct. 26, 1878.

**On a case of impetigo figurata simulating lupus.**—The most important points in the differential diagnosis between the two affections, as shown by W. YEATS, are the presence in the former of impetiginous pustules, followed by thick scabs the consistence of the red patches of skin, which in impetigo are dense, tough, and resisting, and in lupus soft and friable, and the absence of tubercles in the former. Also the complete restoration of the skin to its normal condition after impetigo.—*Lancet*, Aug. 3, 1878.

**Summer prurigo.**—Mr. HUTCHINSON describes a disease which usually appears at puberty, and is characterized by the eruption of small red papules, principally upon the face and upper extremities, which do not become pustules, do not ulcerate, and disappear, leaving behind them minute scars. The disease differs from the prurigo of Hebra, in that the itching is less intense, the face is always affected, the extremities less than other parts, and that this disease is always worse in summer, never during the winter. It also yields to treatment, which the prurigo of Hebra never does. Most of the fourteen cases which he reports were benefited or cured by arsenic internally, and ointments of lead or mercury.—*Medical Times and Gazette*, Feb. 16, 1878.

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## PARASITIC DISEASES.

GEORGE H. ROHÉ, M.D.

**The condition of the skin in tinea tonsurans.**—Dr. GEO. THIN gives an account of the appearances seen in sections through the entire thickness of the skin of a horse affected with ringworm. The skin was examined in both the earlier and advanced stages. The spores of trichophyton were found among the most superficial scales of the horny layer of the epidermis. They were found in the cutis only on the shaft of the hair, and between the shaft and internal root-sheath. The spores in no instance were found in the root-sheath, the hair-root, or hair-papilla, nor in the connective tissue surrounding the hair-follicle,—that is to say, the spores were never found in actual contact with living tissue, the space between the internal root-sheath and the hair-shaft being analogous to the most superficial stratum of the horny layer. The affected hair first bent, and then broke, at a point usually midway between the rete mucosum and the hair-root. This the author attributed to the disintegrated hair yielding to the pressure produced by the normal growth of the hair-shaft upwards. The changes found in the tissues of the cutis and rete mucosum were sometimes extensive, and were similar to those found in inflammation, from whatever cause it arose. The spaces between the bundles of connective tissue were more or less infiltrated with colorless blood-corpuscles (pus-cells), the walls and immediate neighborhood of the blood-vessels being thickly studded with them. Retrogressive changes were found in the nuclei of the cells of the rete mucosum, and at some parts the epidermis had completely broken down, leaving the cutis denuded. In the latter case the surface was found covered with pus-cells. Small localized abscesses were found in the external root-sheath and in the rete mucosum. The cell-infiltration descended along the veins to the deepest parts of the cutis.

The author finding these well-marked inflammatory effects in tissues which contained no vegetable organism, suggested that they were due to the irritation which is produced by the absorption of soluble matter set free during the growth of the fungus. The parasite found its pabulum among effete epidermic structures, and could only assimilate by decomposing them. This theory seemed to be the only reasonable one, because the effects produced were far in excess of those which might be expected to follow the distortion of the hair. The incapacity on the part of the fungus to exist in living animal tissues explained the *modus operandi* of the very numerous methods of curing ringworm. Many of the substances applied were simple irritants, while the parasiticides in common use were also irritant. Inflammation, when sufficiently acute, cured ringworm, as was shown by the fact adduced by the author, in which a simple

wound through a ringworm spot cured the whole patch. It was thus that the beneficial effect in chronic cases of a continued slight congestion was explained. The author further pointed out the probable injurious effect on the general health of the continued absorption of the irritating matters produced by the growing fungus.  
—*Lancet*, March 30, 1878, p. 459.

**Herpes tonsurans and area Celsi.**—P. MICHELSON reports a series of extremely interesting cases of area Celsi (alopecia areata), and discusses at length the etiology of the affection. He considers the parasitic theory of its origin as entirely exploded, while the tropho-neurotic theory of Baerensprung rests upon too slender a foundation to be accepted. The deficiency of nutrition, which is evidently at the bottom of the affection, is not necessarily dependent, according to Michelson, upon the assumption of trophoneurotic disturbance. Inasmuch as alopecia areata generally occurs in individuals exhibiting a depraved condition of the general health, with abnormally thin skins, absence of subcutaneous connective tissue, and anæmia of the skin, the author is disposed to attribute the disease to cutaneous atrophy, possibly preceded by obliterating endarteritis of the cutaneous vessels. [As a theory of causation this seems to have a still smaller basis of facts than either of the others.]—*REP.*—*Volkmann's Sammlung Klin. Vorträge*, No. 120.

**Eczema marginatum.**—A case is reported by Dr. HAZLEHURST, in which a solution of chloral hydrate ( $\frac{5}{j}$ — $\frac{3}{j}$ ) effected a cure within five days.—*Phil. Med. and Surg. Reporter*, July 27, 1878, p. 87.

**Tinea trichophytina unguium.**—Professor DUHRING reports very fully a case of this rather rare affection. Besides the disease of the nails, the patient had patches of tinea trichophytina scattered over the general surface of the body. The treatment adopted was to scrape away daily as much of the nail substance as possible without giving pain, following this with potash soap and water, applied by means of a brush, and afterwards by an alcoholic solution of bichloride of mercury, of the strength of three grains to the ounce.—*Phil. Med. and Surg. Reporter*, Aug. 31, 1878, p. 89.

**Pityriasis capitis and alopecia.**—M. MALASSEZ believes he has demonstrated beyond doubt the constant existence, and very great abundance, of a certain fungus, consisting solely of spores, as causative of the above affections. These spores are found in the horny layer of the epidermis, where they form horizontal strata, or veritable heaps, between the different layers of cells. There is at the same time a vesicular alteration of the epidermic cells already described by Rinvier. The treatment recommended by Malassez differs very slightly from that laid down by Hebra and Kaposi, Neumann, and others of the modern German school.—*Journal de Médecine*, Dec. 1877; *Canada Med. Record*, July, 1878, p. 257.

**Alopecia areata.**—Dr. CHARLES R. DRYSDALE still holds on to the parasitic theory of the origin of alopecia areata, or, as he terms it, *tinea decalvans*. Those who had not found the parasite (he says) did not know how to look for it. [A case of true scientific modesty!—REP.] It is not found on the hairs, but on the epidermic scales which exist on the denuded spots of hairy scalp. [?—REP.]—*Canada Med. Record*, July, 1878, p. 248.

**Ringworm complicated by tinea versicolor.**—Mr. MALCOLM MORRIS reports an interesting case of *tinea trichophytina* complicated—or, rather, followed—by *tinea versicolor*. Although inclined to believe that the fungus of the latter is but a developmental stage of the *trichophyton*, facts at present do not yet warrant such a conclusion.—*Lancet*, May 18, 1878, p. 720.

**Treatment of pityriasis versicolor.**—HARDY uses sulphur baths, or an ointment containing half a drachm of sulphur and ten drops of nitric acid in the ounce of lard. Internally he gives, in severe cases, mineral waters, followed by arsenic. Besnier prefers baths or lotions, containing bichloride of mercury; or, in other cases, frictions with soft soap, followed by an ointment of turpeth mineral 3ss to lard 3j.—*Lyon Médical*, May 5, 1878; *N. Y. Med. Record*, June 29, 1878, p. 518.

**Treatment of favus.**—VIGER cured two cases by application of oil of cade twice a day, after washing the head with soap and water. Treatment lasted two months.—*L'Année Médicale*, April, 1878; *N. Y. Med. Record*, June 29, 1878, p. 518.

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## II.

### SYPHILIS AND VENEREAL DISEASES.

#### GENERAL QUESTIONS IN SYPHILIS, THERAPEUTICS, ETC.

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**On a case of syphilitic re-infection.**—VENOT's case seems reliable, and may be added to those already possessed by the profession. A man of 35 has chancre followed by secondary symptoms and several relapses. His malady is light and his mercurial treatment short. Three and a half years afterwards he gets two indurated chancres with indurated ganglions and a macular syphiloderm, lasting three weeks. All these symptoms disappear without treatment, and nothing further occurs up to the date of the report of the case.—*Le Bordeaux Méd.*, No. 13, 1877; *Jahresbericht f. gesammt. Med.*, Bd. ii. Abt. ii., 1878, p. 527.

**Contamination of a healthy child by the milk of a syphilitic wet-nurse.**—This observation of CERASI pretends to show that a healthy child, three months after having been entrusted to an apparently healthy nurse, became syphilitic without any sore upon the mouth, the nipples of the nurse also being unbroken. The child promptly got general symptoms, and died in convulsions. Section showed, among other things, two gummata in the pia mater, gummata in the lungs, and an indurated liver. It now transpired that the nurse had had a chancre two months before taking the child.

[This case shows the carelessness with which generalizations are

made concerning syphilis. The child becomes syphilitic with a general eruption, and then for the first time the nipples of the nurse and the mouth of the child seem to have been inspected. No sores are found on either, but the nurse, who is declared to have become pale and yellow and to have had nocturnal headache and rheumatic pains, is discovered to have had a chancre five months previously, and immediately the medical world is favored with the information that syphilis has been acquired by a healthy child from a syphilitic nurse through the medium of the milk alone.

The child's symptoms commence at three and a half months from birth, with roseola, vomiting, and diarrhoea. A week later it has mucous patches on the anus and in the mouth, and then loses its voice and has snuffles; then nodes on the bones, convulsions, and soon death. The autopsy shows lesions of inherited disease, although the bones do not seem to have been examined and nothing is said of the thymus. The parents of this child are declared healthy, but surely Cerasi has assumed a great responsibility in pronouncing them so.—REP.]—*Gaz. di Roma*, July, 1877; *Jahresbericht f. gesammt. Med.*, Bd. ii. Abt. ii., 1878, p. 520.

**Inoculation of the secretion of indurated chancre and of condylomata upon syphilitic patients.**—As a contribution to the study of syphilitic contagium, one of the results of the experiments of A. ZAREWICZ, of Krakau, should go on record. Zarewicz, it appears, inoculated upon healthy individuals the pus obtained from inoculations of syphilitic products upon syphilitic patients, carefully avoiding all mixture of such pus with the blood of the patient furnishing it (the pus). The result is stated to have been in every case negative, while the simultaneous inoculation of the same secretion upon syphilitic patients is stated to have produced positive results. The author believes that the ulcers produced upon syphilites by inoculation of syphilitic pus, etc., are of a nature purely inflammatory.—From a review by Ettinger, of Krakau, for the *Jahresbericht ueber die Leistungen und Fortschritte in der Gesammten Medicin*, II., ii., p. 529, 1878.

**On syphilitic inoculation of animals and the nature of the syphilitic contagium.**—KLEBS recently announced the following discoveries at Cassel at a meeting of naturalists there assembled. He had cultivated certain little slowly-moving rods, which he found in freshly-extirpated Hunterian chancres, and then injected a small portion of the resulting cultivated plant under the skin of animals. He publishes some of his results in this article, leaving others for a later exhaustive essay.

In apes he got by such inoculations symptoms similar to those produced by syphilis in man. July 8, 1875, he injected a little of this material in two places under the skin of an ape. About the middle of August, 1875, the animal developed a swelling on the tongue and another on the gum, turning later into unhealthy ulcers, resembling those produced by syphilis upon man in the same situa-

tion in clinical appearance as well as in histological details. Prof. Pick recognized the resemblance. The animal was killed September 1, 1875. Yellow, cheesy masses similar to those seen in man were found deposited between the dura mater and the skull. Microscopically, these masses showed spindle-cells (which are very characteristic of syphilomata in this region) and a quantity of little rods and threads analogous to those forms seen in the cultivated parasite which had been injected. Moreover, the animal's lungs were the seat of extensive changes, partly cheesy and in part consisting of connective-tissue thickening, with numerous deposits on the pleura. The kidneys also presented several tumors of the size of a pea, partly cheesy, partly fibroid. There were, however, in several organs, especially in the liver, little collections of cells exactly resembling true miliary tubercle.

December 29, 1877, a healthy female ape was infected by having a portion of a freshly-extirpated Hunterian chancre placed under her skin. The wound healed without suppuration; the neighboring glands swelled slightly. Six weeks after the inoculation the animal became feverish, and in a few days a steadily-increasing number of papules appeared upon the face, neck, head. These were flat, solid swellings of the integument of from two to three millimetres diameter, of brownish-red color. After a time the epidermis became partly separated from the top of these lesions by a slight serous collection, which, however, did not form a vesicle, but as a rule quickly dried up. No ulcerations appeared. As the fever ceased the papules disappeared, without leaving any trace. No new febrile symptoms ensued, but on the 17th of May, 1878, five months after the inoculation, having gradually lost strength, the animal died. Under the site occupied by the papules, where no deep lesions had been obvious during life, the macerated skull showed clearly certain changes in the superficial portions of the bone, the syphilitic nature of which could not be doubted by any one familiar with these changes as they appear in man, due to syphilis. The changes observed were those due to periostitis and caries sicca. A spindle-celled connective-tissue focus was found in the lung, with extensive, radiate, fibrous thickening of the pleura over it, very similar to what is found in human pulmonary syphilis. The kidneys contained also several tumors composed exclusively of spindle-formed cells exactly similar to what is seen in fresh forms of true syphiloma, and beyond the suspicion of being confounded with tubercle.

The cultivation of some blood taken from the body of this ape yielded plants bearing a great resemblance to those used for inoculating the first ape.

The parasite consists, during its development, first of movable, then of stationary rods, and, growing from the latter, spiral masses of linked rods. Klebs considers the plants the sole cause of syphilis, and names them *Helikomonads* (*Helix* and *monas* of Ehrenberg). He leaves to botany the task of their accurate classification. [These researches, if substantiated by further investigations, are of

the utmost importance.—REP.]—*Allg. Wiener Med. Zeitung*, October 15, 1878, p. 418.

**Irritation and syphilis.**—Investigations undertaken by TARNOWSKY, to determine the behavior of healthy and of syphilitic skin under irritation, led him to the following conclusions:

1. The skin reacts under irritation more promptly and more considerably in the secondary than in the tertiary stage. The nearer the time of irritation to the outcrop of the first eruption the greater is the local effect produced by mild irritation upon syphilitic subjects.

2. The quality of the syphilitic symptoms exercises a decided influence upon the intensity of the result produced by local irritation. Suppurating sores exactly resembling soft chancre are produced much more readily upon patients with suppurating and ulcerative lesions by means of local irritation than upon those whose lesions are dry (papular, squamous, tubercular).

3. Young, blonde, anaemic women, with little fat and a fine skin, respond most positively to local irritation. Scrofula, mercurialization, scurvy, and alcoholism considerably intensify the irritability of the skin.

4. In a given case the inoculation of the secretion of a mucous papule, or of other syphilitic lesions produces just the same lesions as the inoculation of pus or of any detritus, not syphilitic, or of a chemical irritant. The variety in the appearances noticed at the point of inoculation depends upon the grade of the irritation, not upon the presence or absence in the matter inoculated of a syphilitic contagium.

5. The inoculation upon a syphilitic person of any irritant of given intensity first produces a pustule. Around this a syphilitic deposit takes place, and an ulcer is the ultimate result. Bidenkap, Reder, Köbner, and others consider these cutaneous ulcers to be soft chancres. They differ from soft chancres, however, in their appearance, their course, the absence of suppurating bubo, and finally in that their inoculation upon healthy subjects produces syphilis, and not soft chancre. [Cases are not referred to in proof of this last statement.—REP.]

If the inoculated substance is not sufficiently irritating, or the patient not suitable for inoculation, an abortive pustule follows, or the result is entirely negative. Sometimes a slight (four to five days) inflammation is provoked by the inoculation. A week afterwards a syphilitic papule begins to appear upon the same spot. This lesion has been denominated primary syphilitic induration by Boëck and Bidenkap. It is a syphilitic papule, produced by slight local irritation upon a syphilitic subject.

6. Köbner's theory that the development of a soft chancre depends upon the introduction of a contagium under a skin which contains the contagium already in a concentrated form, and that the existence of a hard chancre depends upon the action of the same, but diluted, contagium, is overthrown by direct experiment. Tar-

nowsky practised inoculation upon sound men with the secretion of soft chancres, diluted with indifferent substances. Chancroidal pus thinned to a certain degree caused the development of soft chancres. The inoculation of a pus still further reduced gave abortive pustules. A still further reduction of the pus yielded nothing on inoculation. No grade of concentration of chancroidal pus succeeded by inoculation upon a healthy person in producing primary syphilitic induration.

7. When a chancroid develops upon a syphilitic individual it may call out a local syphilitic infiltration,—pseudo-indurated chancre of syphilis. This lesion is with difficulty distinguished from primary infecting chancre. The author considers all cases where, after indurated chancre no general symptoms follow, to be pseudo-indurated chancre, whether attended by suppurating bubo (as they may be) or not. In this way Tarnowsky explains the occurrence in one man of an indurated, in another of a soft chancre, derived from contact with the same woman having chancroid. He also thinks that in the same way may be explained how a woman may give one man syphilis, another only chancroid. She has a pseudo-indurated chancre. At first (nine to twenty days) sound men get only chancroid, syphilitics get pseudo-indurated chancre. Later, when the syphilitic quality has impressed itself upon the secretion of the sore, the syphilitic still gets pseudo-indurated chancre, while the healthy man gets a mixed chancre (Rollet), followed by constitutional syphilis.

8. Pseudo-indurated chancre differs, as follows, from chancroid with an inflamed base. The inflamed base is due to an irritation of the surface of the chancroid, and corresponds to the rapidity of the ulcerative process. With a decrease of symptoms of irritation in the ulcer, the surrounding hardness correspondingly diminishes. The induration disappears with cicatrization. The infiltration about a pseudo-indurated chancre, on the contrary, increases independently of the course of the ulcer. The ulcer heals, but the infiltration increases up to a certain time, and is then also absorbed. An inflamed chancre is commonly painful, a pseudo-indurated chancre but slightly so. The inflammatory induration is softer, more yielding, not so sharply defined as the cartilage-like induration of pseudo-indurated chancre.

Pseudo-indurated chancre differs from primary infecting chancre in having no incubation period, no effect upon the lymphatic vessels or glands (exceptionally a suppurating bubo attends it), absence of secondary syphilitic symptoms, origin from a soft sore.

Tarnowsky further—employing Ricord's paste of sulphuric acid and charcoal (on two hundred syphilitics and fifty patients with chronic maladies of the skin and internal organs)—endeavors to bring out local evidences of syphilis upon the skin, by means of irritation, to confirm diagnosis or to decide whether the patient is actually free from syphilis. He concludes,—

i. A positive result of "cauterisatio provocatoria," as he calls

it, proves the existence of syphilis. A negative result does not prove the contrary.

2. A positive result consists in the appearance of a dark-red border,—not disappearing under pressure,—first coming on after the total subsidence of the inflammatory reaction produced by the cauterization. This band—three to five mm. broad, sharply bordered, indurated—grows gradually, and assumes a brown tint. After twenty to thirty days it begins gradually to sink, and disappears. Simultaneously with the appearance of this border there forms beneath the cauterized area a sharply-bordered induration, which increases for fifteen to twenty days, and then slowly disappears.

The absence of any one of the above appearances makes the result of cauterization fail of being convincing.

Now the scab falls, another takes its place, and finally round or serpiginous ulcers, papules, ecthymatous pustules or tubercles appear around the injured spot to increase the positive result of the cauterisatio provocatoria.

3. If the inflammatory results of the cauterization do not disappear by the tenth to the fifteenth day, the phenomena first mentioned above cannot be observed, and the cauterization loses its diagnostic value. Prolonged inflammation is most apt to be observed in non-syphilitic, weakened, cachetic persons.

A separation of the scab in the first five to ten days interferes with an accurate observation of the result of the cauterization, as does also the appearance of eczema, erysipelas, furuncles, etc., about the focus of irritation.

4. The younger and healthier the person, the less irritable the skin, the more valuable the results to be derived from cauterisatio provocatoria.

5, 6, 7. The nearer the chancre the more likely is cauterisatio provocatoria to give a positive result,—that is, to call out symptoms evidencing the existence of syphilis.—*Vierteljahrsschrift für Derm. u. Syph.*, IX. Jahrg. Zeit., 19. Jahresb. f. gesammten Med., II., ii., p. 525.

**Chancriform syphilides of the genital organs.**—Dr. CHARLES ANGELON calls attention to two lesions of syphilis which have long since been described, but are not common enough to be easy of recognition by the general practitioner as a rule.

The two forms are (1) an ecthymatous lesion or a superficial gumma, sometimes an eroded syphilitic tubercle appearing on the penis upon a site ordinarily occupied by an infecting chancre, having an indurated base and generally mistaken for a chancre. Sometimes such a case is reported as one of second infection in an individual already syphilitic. The lymphatic glands may become swollen (indolently) so as to resemble the ganglionic pleiad of true syphilis, but secondary symptoms of course do not follow, and confrontation yields a negative result [while the history and perhaps concomitant symptoms show the patient to have been already syph-

ilitic.—REP.]. (2) The chancriform syphilide resembling chancroid upon the genitals may be attended by sympathetic inguinal bubo, which may suppurate, but the result of auto-inoculation is negative, as is also confrontation. [It might be added that this syphilide has a more or less hardened base, although in other respects resembling chancroid, that its course is totally different from that of chancroid, its commencement generally a solid gummatous infiltration, its progress slow, and that it does not get well after cauterization.—REP.]

Angelon has seen five chancriform syphilides. He believes them to be more common in the male.—*Thèse de Paris*, 1877. *Jahrsb. f. gesammt. Med.*, Bd. ii. Abth. ii., 1878, p. 518.

**A rare form of syphilitic eruption following a chancre of the tonsil.**—The eruption here reported by HARDY was polymorphous (vesicular, pustular, erythematous, and papular), somewhat resembling variola in certain places. The most interesting portion of the article is a section near the end, in which Hardy states that about two years previously a specialist in ear-disease had inoculated a number of people by passing a soiled Eustachian catheter upon them. The number of victims, Hardy says, was estimated at thirty or forty, and he (Hardy) had treated five individuals who had acquired their syphilis in this way.—*Gaz. des Hôp.*, Sept. 10, 1878, p. 833.

**Diffuse hypertrophic syphilide of the face.**—M. RAYNAUD reports the case of a syphilitic woman of 59, who, together with other symptoms of syphilis, suffered from an hypertrophy of the nose, cheeks, lips, chin, with deepening of the furrows, giving her a leonine aspect. The coloration was dead, brownish, coppery, the sensibility intact, the integument supple and elastic to the touch. Anti-syphilitic treatment caused these symptoms to diminish notably.—*Soc. Med. des Hôp., Union Méd.*, June 4, 1878. *Rev. des Sci. Méd.*, No. 24, Oct. 15, 1878, p. 609.

GOUTARD's thesis, 1878, *Du Leontiasis Syphilitique*, covers the same subject.

**Clinical essay on tertiary syphilis of the lymphatic glands.**—PAUL GONNET concludes that—

1. Syphilitic tertiary adenopathy is rare.
2. Visceral ganglia are more frequently involved than the superficial. Of the former, the pre-vertebral and iliac; of the latter, the submaxillary, inguinal, and cervical suffer most often.
3. Commonly (not necessarily) there are accompanying visceral tertiary lesions.
4. The disease occurs in two forms, (1) sclerotic, (2) gummatous, or both may co-exist. The glandular tumors are elastic, movable, not adherent to the neighboring tissues, indolent. Untreated, they may soften, and, ultimately opening, discharge a sticky, yellowish fluid. Remaining open, they present the aspect of syphilitic ulcers.

5. But few ganglia are involved in a given case,—at least of the superficial ones.
6. The tumors may be confounded with scrofulous, tuberculous, and cancerous glandular enlargements.
7. Prognosis is not bad—usually.
8. Treatment is that of tertiary syphilis, with tonics and anti-scrofulous remedies.—*Thèse de Paris*, 1878, *Rev. des Sci. Méd.*, No. 24, Oct. 15, 1878, p. 607.

**Case of tertiary syphilis with exfoliation of the whole anterior surface of the axis.**—In BECK's case the patient had been treated interruptedly for syphilitic lesions. Eight years and nine months from the date of the chancre, after a gummy tumor of the fauces lasting three weeks, a bone was coughed up which was recognized as the anterior surface of the second cervical vertebra. The patient recovered. He had been married during his nine years of syphilis, and his wife, who had remained well, had been delivered of several children, who were born free from signs of syphilis and had continued healthy.—*Dublin Journ. Med. Sci.*, Feb. 1878; *Jahrsbrcht f. gesammt. Med.*, Bd. ii. Abth. ii., 1878, p. 520.

**Exulcerative syphilitic hypertrophy of the neck of the uterus.**—Dr. A. MARTIN states that in about 48 per cent. of all cases in women during the early secondary period of syphilis the uterine neck hypertrophies, sheds its epithelium, looks varnished, of a livid hue, and suppurates slightly without ulceration. There are no subjective symptoms of inflammatory disturbance affecting the utero-ovarian system.

The malady comes on, on an average, fifty-eight days after the appearance of the chancre, sometimes preceded by fever. It customarily co-exists with secondary hypertrophy of the tonsils, to which it is quite analogous. The secretions from the lesion are contagious, but not auto-inoculable. Four or five weeks of internal treatment cause its disappearance. Local treatment alone is of little or no value. De Fourcault's Thesis (1878) is referred to.—*Ann. de Gynecol.*, Nov. 1877; *Rev. des Sci. Méd.*, No. 24, Oct. 15, 1878, p. 607.

**Chancrous erythematous-elephantiasic unilateral vulvitis.**—GOSSELIN states that a vulvitis of only one of the labia majora, erythematous in quality, and very slow in progress, attended by enough interstitial thickening to justify the name elephantiasis, is an occurrence not very uncommon. He claims to be the first to have described it, and states that it follows and is always due to chancre as a cause, and that this chancre, in the great majority of instances, is of the infecting variety.—*Gaz. des Hôp.*, 89, 1877, p. 705.

**Syphilis of the muscles.**—MAURIAC's lectures on this subject, which are reprinted from the *Ann. de Dermat. et de Syph.*, vols. vii. and viii., will be found noticed in full in the Review department, page 108.

**Case of secondary syphilis treated by hypodermic injection of mercurialized peptone.**—The strength of solution injected by BISHOP was one hundred minims of peptone (made by Darby & Godson) and one grain of corrosive sublimate. It is only necessary to say that hard, painful nodules persisted a long time at the seat of puncture. [Buzzard's previous trial of this method (*Brit. Med. Journ.*, Sept. 28, 1878, p. 475), leading to the same result, does not seem to have discouraged Bishop.—REP.].—*Brit. Med. Journ.*, Oct. 26, 1878, p. 627.

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#### CHANCRE AND CHANCRION AND THEIR COMPLICATIONS.

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## INFANTILE AND CONGENITAL SYPHILIS.

JAMES NEVINS HYDE, M.D.

**Hereditary transmission of syphilis.**—In the first of BALDWIN's cases, a wife, infected by her husband, soon after became pregnant and bore: first, a seventh-month dead foetus; next, twins, who died of syphilis when six weeks old; next, a girl, who died syphilitic in the third month; next, after anti-syphilitic treatment during pregnancy, a boy, who was free from the disease in the sixth year; next, after anti-syphilitic treatment during pregnancy, a girl, who survives, exempt from the disease; next, a child, which soon exhibited symptoms of marasmus and syphilis, and who weighed, when two and a half months old, only four and a half pounds. The mother had not been treated during this last pregnancy. Soon, however, the little patient improved in health, the syphilitic symptoms disappearing. Later, brain syphilis produced epileptiform convulsions.

In the second case reported, a mother, up to that date free from symptoms of syphilis, brought into the world an infected child, in 1874. In 1876 there was an explosion of constitutional disease and treatment for two months. In 1877 a healthy child was born, though, during pregnancy, the patient had been infected by her husband with the chancroid disease.—*Phil. Med. Times*, Aug. 17, 1878.

**Transmission of syphilis from parents to offspring.**—The conclusions drawn from HUTCHINSON's thirty-six cases are: (*a*) it is possible to transmit syphilis from parent to child seven years and more after date of infection; (*b*) the intensity of hereditary syphilis is not dependent upon the question whether one or both of the parents suffered from the disease; (*c*) syphilis of the mother is intimately associated with the frequency of the hereditary disease; (*d*) the older the syphilis of the father the greater the prospect of immunity for the infant; (*e*) syphilis of the father does not invariably engender syphilis of the child; and (*f*) infection at the moment of conception transmits the disease by inheritance, while syphilis transmitted at any subsequent period of intra-uterine life

is an acquired form of the disease.—*Brit. and For. Med.-Chir. Rev.*, Oct. 1877, No. 120, p. 455.

**Syphilitic infection of an infant at the time of birth.**—Professor WEIL relates the case of a woman suffering from labial condylomata and post-cervical, inguinal, and epitrochlear adenopathy, who bore a perfectly sound infant. In four weeks a sore appeared at the root of the child's nose. The latter remained for seven weeks in a perfectly healthy state, but displayed, eleven weeks after birth, a generalized maculo-papular syphiloderm, and various other typical lesions, which were relieved by appropriate treatment. The author claims that this is a case of *infectio per partum*, and that the infant had acquired and not hereditary syphilis, because (*a*) the facial sore was a genuine primary lesion, occurring after four weeks of incubation; (*b*) was followed by a secondary incubative period of seven weeks; (*c*) was succeeded by a classical eruption similar to that observed in the acquired disease of adults; (*d*) the child was well nourished and suffered from no coryza, palmar and plantar indurations; (*e*) the mother having acute syphilis, if the disease of the child had been transmitted by her, the symptoms in the case of the infant would not have been so tardy in appearance; and (*f*) the position of the child's head during parturition was such that, if inoculated from the condylomata, the lesion would have occurred precisely where it did, at the root of the infant's nose.

[Reports of cases where syphilis is supposed to have been transmitted from mother to child during the contacts of labor are open to suspicion: (1) because of the rarity of such occurrence; no well authenticated case of this accident is on record; (2) because the vernix caseosa of the foetus is a most admirable protection against such an accident; (3) because the gush of amniotic fluid and blood, which precedes the passage of the child, is sufficient to temporarily cleanse any secreting lesions of the external genitals; (4) because traumatism is usually requisite for infection by the skin, and such traumatism is necessarily very rare in the unborn child unless severe mechanical injuries have resulted from instrumental delivery,—even the finger of the accoucheur enjoys immunity when the skin is unbroken; (5) because so many children have completely escaped this peril. For two instances in which infants have thus escaped, consult *Violet, Etude Pratique de la Syph. Inf.*, Paris, 1874, p. 11,—the mother at the moment of parturition having exhibited initial lesions of the vulva.—REP.]—*Wien. Med. Presse*, 1877, p. 1483.

**Syphilis communicated to a child by means of the saliva.**—Dr. BÖTTGER reports the case of a girl 9 years old, who had bilateral iritis for which no cause could be discovered. She had always been healthy, and neither parent showed traces of syphilis. The child had been brought up by the bottle, and no suspicion attached to the nurse. Upon examination of the latter, however, the author detected nasal deformity due to loss of septum, and she admitted former vaginal and anal lesions, also having on occasions

chewed the food of the child in her own mouth before its administration. Under specific treatment the iritis was relieved, not, however, before perforation of the hard palate occurred, with permanent loss of tissue.—*Memorabilien*, ii., 1878.

**Contagion and hereditary syphilis.**—Dr. CARLE reports the case of an infant 2 months old, its body covered with macular and ulcerative lesions; mucous patches of vulva, anus, and mouth; pemphigoid bullæ of the feet. The father admitted pre-marital syphilis, and the mother exhibited lesions in the early months of pregnancy. The nurse who gave her breast to this child had several ulcerations in the vicinity of the nipple, followed by classical symptoms of syphilis.

The author, taking this as his text, makes some sensible observations upon the dangers attending the marriage of syphilitic patients, and the difficulties surrounding the attempt made by him to conceal the nature of the malady from those interested in protecting themselves from infection.—*Lyon Médical*, July 21, 1878, p. 417.

**Syphilitic nurses and infants.**—Dr. CHARLES DRYSDALE, of London, contributes a brief abstract of Fournier's excellent lecture on syphilitic nurses and nurslings,—a paper to which we have on several occasions called attention. Drysdale, however, puts the following absurd phrase into the mouth of the French author: "absolute impossibility of continuing to suckle by any nurse." What Fournier meant was simply this,—"breast-nursing positively prohibited."—*The Doctor*, March 1, 1878, p. 63.

**Vaccination in syphilitic subjects.**—Dr. PRATT, in a communication to the *British Medical Journal*, declares that it is impossible to "get a well-formed vesicle in a congenitally-syphilitic infant." He states that he has in numerous instances vaccinated infants with fresh lymph from healthy sources; that these infants had been previously treated for congenital syphilis, but were, at the time of vaccination, perfectly free from all eruptions, snuffles, or external lesions, and that a negative result was constant. Sores were found discharging an ichor-like material, but no true vesicles resulted. He is uncertain whether these were protective processes.

[But such typical vesicles have been obtained frequently in syphilitic infants by other vaccinators. Speaking for Americans only, we may mention the name of Ware, of Chicago (*Chicago Med. Exam.*, 1873, p. 253), who, with great precautions, vaccinated successfully a healthy child from lymph taken from a characteristic vesicle upon the arm of an unmistakably syphilitic infant, and with impunity (being himself protected by previous vaccination) introduced the same matter under his own skin. We suspect that Dr. Pratt's lymph or his method was at fault.—REP.]—*Medical and Surgical Reporter*, August 31, 1878, p. 195.

**Syphilis in a child which did not result from vaccination.**—Dr. L. P. YANDELL reports that he was refused permission

to vaccinate a child which, five weeks afterward, exhibited a cutaneous syphiloderm. Strict inquiry failed to elicit a history of parental disease, the father having suffered from "erysipelas." The inference is obvious.—*Louisville Med. News; Pacific Med. and Surg. Journ.*, April, 1878, p. 520.

**Casts of the mouth in congenital syphilis.**—Dr. WILLIAM PORTER exhibited to the St. Louis Medical Society a pair of casts of the mouth, one taken from a child affected with hereditary syphilis, the other, by way of contrast, from a healthy child. He called attention to the increased height of the bony roof of the mouth in children who are subjects of the disease. The angle of junction of the palatal processes of the superior maxillary bones, together forming the palatal vault, is often more acute than natural in such patients. The teeth are roughened, and the central upper incisors are pegged.—*St. Louis Medical and Surgical Journal*, April, 1878, p. 303.

**Purpura and omphalorrhagia in hereditary syphilis.**—BEHREND's paper (read before the *Berliner Med. Gesellschaft*) described purpuric and omphalorrhagic symptoms observed by himself in several cases of congenital syphilis. Cutaneous ecchymoses appeared in some of the patients; in others, hemorrhage from the navel after the sundering of the umbilical cord, termed by Zeissl *syphilis hemorrhagica neonatorum*.

In the first child, well nourished and born at term, a scaly syphilitide was succeeded by numerous pin-head sized petechiæ, which disappeared after the use of baths of corrosive sublimate. The child had other symptoms, and died in its fourteenth month, hydrocephalic.

A second infant, well nourished and at term, respiration but for a brief time. Its body was seen to be uniformly covered with abundant petechiæ and ecchymoses. Post mortem, there were pulmonary, hepatic, splenic, and osseous symptoms of syphilis.

The author believed that many other cases could be cited where no syphilitic cause had been suspected, because hitherto the hemorrhage has been thought to depend upon other influences.

Omphalorrhagia is of rarer occurrence than the purpura described above, the author having observed five cases, three successively in one family, where the father had displayed suspicious symptoms. Of these children, the second was quite fleshy, and had epidermal exfoliation of the palms and soles. The third was cachectic, and the hemorrhage from the navel was associated with cutaneous ecchymoses.

In explanation of these phenomena, Behrend turns to the possibility of changes in the vascular parietes under the influence of the specifically-altered blood. Though similar to the phenomena of ordinary haemophilia, the symptoms observed by him are seen to differ in this, that the former are idiosyncrasies of an entire family, and that the ecchymoses only succeed traumatism; in syphilis these

last occur spontaneously. Hemorrhage from the navel in children, where haemophilia is a family peculiarity, always occurs before the separation of the cord-remnant. This is not true in syphilis. In the first instance we have the symptom of a permanent and life-long anomaly; in the second, the expression of a transitory diathesis.

In the discussion which ensued, SIMON referred to the fact that hemorrhage occurred not only in hereditary but in acquired syphilis, and whether in either case it resulted from the disease itself or from the induced cachexia was a matter of doubt. Various other cachexiae were often the cause of similar symptoms, and the occurrence of gangrene in one of Behrend's cases was a significant fact. Occasionally in the syphilis of adults could be noted coexistent purpura of the inferior extremities and roseola elsewhere. The exit of blood from the vessels was common in many disorders, for example in variola, and Cohnheim had demonstrated diapedesis of red corpuscles under certain conditions of blood-stasis.

HENOCH, agreeing with the last speaker, called attention to the fact that pemphigus had been once considered a specific symptom, and that Cailloux had shown the contrary. All ill-nourished syphilitic infants were cachectic, and, as distinguished from the patients observed in private practice, so were the larger number of those treated at the clinics. The latter displayed a long list of cachectic symptoms, including eye lesions, rupia, and hemorrhages. He had never seen extravasations of blood, either from the navel or the skin, in well-nourished children. All the syphilitic children seen in the public charities were hopelessly doomed to cachexia; remedies in turn failed, and often post mortem no cause of death was evident. Even in cachexia not of syphilitic origin hemorrhages were frequent. He could not, therefore, unreservedly accept the existence of hemorrhagic syphilis.

BEHREND responded that some of his patients had been fat and well nourished, and that the hemorrhage had been too abundant to be explained in any other way than by vascular rupture; SEEMAN confirming the statement as true of one of the children seen by him; while STEINAUER, who had examined another, stated that the latter was exceedingly cachectic, post-mortem evidences of syphilis being unmistakable.

HENOCH declared that no proof had been adduced that syphilis was the cause of hemorrhage when the two co-existed; and BAGINSKY cited a case where melæna neonatorum occurred in a child between 3 and 4 weeks old, followed by syphilitic symptoms. If the hemorrhage had been due to the syphilis it would probably have recurred, but did not.

SIMON added that cardiac anomalies might account in some cases for the coincident syphilis and hemorrhage; BEHREND responding that, in his patients, such anomalies did not exist. He laid further stress upon the excellent state of the nutrition noted in some of the children reported on; to which LITSEN replied by stating that

adipose tissue did not disappear always in cachectic states, as, for example, in pernicious anaemia. Among other states in which dia-pedesis occurred, was diabetes with intestinal hemorrhage.—*Wien. Med. Wochens.*, June 8, 1878, p. 319.

**Hereditary syphilis—the bullous syphilide.**—The following is an abstract of four of the valuable lectures lately delivered at the Hospice des Enfants Assistés by M. PARROT.

He introduces his subject with a brief sketch of the history of the literature of hereditary syphilis; commencing with Gaspard Torella (1498) and Matthiole (1536), who concluded that the disease was induced by the milk of infected nurses, and proceeds to the consideration of abortion due to syphilis.

Menstrual irregularities and suppressions in the subjects of syphilis are thought by Fournier to be due to the anaemia and cachexia induced by the disease, precisely as other maladies operate to produce the same effect. In this result, however, Parrot believes the specific disorders of the utero-ovarian apparatus play an important part.

Abortion occurs in a little more than one-third of all pregnant women who are syphilitic. The epoch of the abortion depends upon the age of the syphilis in the woman, and, when recent, upon the period of pregnancy when infection occurred. The more complete the term of pregnancy when contamination happens, the fewer are the chances of abortion; at the fifth month, Parrot believes infection rarely interferes with the gestation.

According to Kassowitz, untreated syphilis of the mother for the first three years of the disease always leads either to abortion or the birth of children which survive but a brief time. Bärensprung is of opinion that it is especially at the 3d, 4th, and 5th months that these accidents ensue. Weber, in 1875, had observed 109 pregnant syphilitic women, one-fifth of whom aborted, generally between the 7th and 8th month.

Parrot, after citing various authorities, expresses no opinion as to the relative share of the parents in this premature expulsion of the foetus, but agrees with all observers in the conclusion that the condition of the product of conception itself is the immediate cause. Babington, Rousseau, and Bärensprung believed that the death of the foetus was the exciting cause; Kassowitz concludes that this is not essential, the greater or less disturbance of its nutrition being sufficient. The lecturer laid no stress upon the anatomico-pathological conditions of the placenta, inasmuch as these are not well understood.

In the matter of treatment, Weber found that 35 women treated by mercurial injection had a normal conclusion of gestation. Of those subjected to mixed treatment (with preponderant employment of potassic iodide), 20 per cent. aborted; of those who simultaneously ingested mercuric bichloride and potassic iodide, 15 per cent.; while of those who took potassic iodide only, 36 per cent. aborted.

Exceptionally, the newly-born syphilitic infant bears the evidences of its disease upon its external surface; in such cases death usually

supervenes rapidly. As a rule, the syphilitic child at birth appears to be healthy. It has a moderate degree of embonpoint, exhibits a rosy or slightly-marbled tint of the skin, its flesh is firm, its cry vigorous, it takes the nipple well, its stools are normal, and its urine clear and abundant. This lasts a fortnight, three weeks, or a month, and then the scene changes. A yellowish discharge from the nostrils accumulates around and obstructs their orifice. Suction of the nipple becomes difficult, painful, and accompanied by cries and agitation. The infant commences to waste. Soon the nates, the upper and posterior surfaces of the thighs, and the periphery of the mouth, the nostrils, and the chin, become covered with an eruption. At the commissures of the lips, fissures and ulcerated papules form.

The eruption becomes rapidly more abundant and salient. Macules are replaced by red or rosy patches, sometimes of a violet tint, which has been compared to the color of the lean part of a ham, with depressed and grayish centre, sometimes scaly or ulcerated, according to its location. Here and there, especially upon the face, brown or reddish crusts appear. The appetite is sensibly diminished; there are frequent stools and vomiting, the dejections of a greenish color and mixed with mucus. The flesh becomes less firm, the integument loses its tint of health, and has a wrinkled look. When the emaciation has somewhat advanced, by examining with the hand the tissues about the inferior extremity of the arm and the internal face of the leg, it can be determined that the humerus is thickened and the tibia is more voluminous than natural, as though something had been added to the thickness of the bone.

The phenomena which succeed are different, according as the disease assumes a chronic or rapidly-fatal phase. In the former case, the eruption both extends to new portions of the integument and becomes more prominent where it had heretofore existed. The buttocks, scrotum, labia, and thighs become covered with elevated and indurated patches, resulting in deep and extensive ulcers. From the eyes, the nose, the ears, and the facial lesions, a puriform matter escapes, which concretes into thick, irregular crusts, producing a most repulsive aspect of the visage, whose features are also disguised by the swelling of the skin. The eyes become closed, the eyelids glued together, the nostrils obstructed, and the lips, which are seamed with deep fissures, bleed on the least contact.

Just before death a notable change occurs. All the lesions subside and lose color, the redness disappears, and the discharge ceases. Only the crusts persist, and even these have lost in volume. At this moment, one who considers the skin alone might conclude that there was an amelioration of the symptoms; in reality, death is imminent.

In the acute form, the phenomena last described are speedily noted. There is no time for the slow evolution of syphilis; some complication or intercurrent affection proves fatal, occasionally even before the identity of the specific disease has been established.

Death, however, is not a necessary result. Under favorable conditions of hygiene and treatment, recovery takes place; macules disappearing first, papules becoming depressed and fading, ulcers healing, often with a permanent scar as the result. The processes of nutrition, temporarily disturbed, resume a normal activity, the flesh becomes firm, and the skin assumes a healthy tint. It is the digestive tube which works this marvel, and it is to it, therefore, that the physician should chiefly direct his attention.

Parrot, reviewing the symptoms detailed above, recurs to the subject of the bullous syphilide, commonly called *pemphigus syphiliticus*, as the most precocious of these symptoms, occurring in a large number of cases at birth, and often dating back to the sixth or seventh month of intra-uterine life.

Seated generally upon the palms of the hands and the soles of the feet, it is also found upon adjacent parts, as the dorsal face of the fingers and toes and the inferior surface of the leg (much more rarely upon distant organs such as the ear). In these latter cases the eruption is usually tardy of occurrence, more discrete, and less developed.

In the first few days after birth the extremities are, as a rule, more deeply congested and colored than other parts of the body. Their hue is of a deep violet shade in the new-born affected with bullous syphilides, and venous red patches may be seen upon them, surrounded by a bright-red areola, whose epidermis is speedily raised by the accumulation of liquid beneath, which transforms the lesions into bullæ of variable size. Their diameter may equal from two or three mm. to one and a half ctm. Their development may be rapid, and coalescence occur, forming a compound bulla, whose contour is formed by a series of segments of circles. Some resemble the pustules of variola, others contain a greenish fluid. The smaller ones are made tense by their contents; the larger are often partially filled merely, the roof of the bulla being partially collapsed upon the fluid contents beneath.

Two important points are to be noted: 1st, The bullæ most distant from the site of election have always less distinctive features than others; they are fewer, smaller, and have less abundant yellow contents. Aborted lesions are to be seen near these, the epidermis being scarcely raised, and without subjacent fluid; 2d, The later the eruption after birth, the less distinctly marked is its type. Hence bullous syphilides, late of occurrence, and seated elsewhere than upon the site of election, may give rise to doubts in diagnosis.

Once fully developed, a portion of the liquid contents may be absorbed and the remainder concrete into a brownish mass; or the cuticle may burst or become completely detached, leaving an ulcer of various extent upon the corium beneath. These ulcers have a red and sanious floor, are not as a rule deep, but are sometimes crateriform and involve all layers of the skin. Generally at this time the subjects of the disease perish.

In the exceptional cases where a cure has been effected (noted by

Depaul, Galligo, Stamm, Hertl, Ollivier, and Ranvier), the general turgescence subsides and the crusts fall, exposing an imperfectly formed epidermis, which is renewed after successive desquamations until it acquires a sufficient firmness to persist.

Of all the cutaneous syphilides the bullous appear at the most fixed time, and are also the most precocious. They have, however, been noted as late as the seventh and eighteenth day, and even at the tenth week.

Bullous syphilides appear simultaneously, rarely by successive crops. Intervals of fifteen and nineteen days have yet been observed, during which time the lesions first to appear have been completely relieved.

There may be coexistence of other syphilides with bullæ, especially when the latter are tardy of appearance. The lesions are not, therefore, as has been taught, uniformly isolated. The minute, very red papules which are rapidly transformed into pustules, and termed "syphilitic ecthyma," are not really such, but constitute one variety of bullous syphilides. "Syphilitic rupia" belongs to the same category. There is really but one disease which requires to be differentiated from that under consideration. It is the pemphigus of the newly-born.

But pemphigus never commences on the palms of the hands and the soles of the feet. If it occur in these situations, it has always first appeared on the neck, axillæ, and upper surface of the thorax, its site of election. In the syphilitic form, the maculæ, which precede the bullæ, the skin from which they are developed, and their surrounding areolæ, are all of a violaceous tint; in non-specific pemphigus the color is a rosy red. The latter, too, are larger, and contain at the outset a transparent, amber-colored serum, which never becomes purulent, made up eventually of water and protein granules with few epidermic cells and leucocytes. Afterward the fluid is either absorbed or results in a thin impetiginous crust, whose fall exposes a delicate layer of epidermis. In syphilis, the bullæ contain pus, and solid elements predominate in the form of fibrinous granules, pus-globules, and whitish flocculi, which are the débris of the mucous layer of the epidermis. Then follows a brownish crust covering an ulcer of the corium. Lastly, syphilis may exist at the moment of birth; pemphigus rarely appears before the fifteenth day, and is frequently observed during the course of the first year.

Is this eruption really syphilitic? Parrot thinks it is so unquestionably. The earlier observers so considered it, and also many of those succeeding them. Some have believed it to be due simply to the cachexia engendered by the specific disease. But cachectic pemphigus is quite different in its date of appearance, seat, external phenomena, and histological lesions. As for the opinion that the disease is sometimes produced by syphilis and sometimes by another cause, Parrot dismisses it with a single sentence, and does not believe that when bullæ are the sole manifestation of syphilis the diagnosis should be doubtful. Observation teaches this truth. In the large

number of infants examined by the author, when pemphigus existed upon other regions of the body than the palms of the hands and the soles of the feet, no visceral nor osseous lesions were in any case discovered.

Exceptionally, a bullous eruption occurs in *acquired* syphilis, the "pemphigoid pustular syphilide" of Alibert. Ricord has seen this once on the soles of the feet; Bassereau once also on the palms of the hands. Zeissl in twenty years never saw it. Morgan reports one case in a woman twenty-six years of age.

From this fact it will be seen that the bullous syphilide is peculiar to the newly-born, and is one of the most characteristic evidences of hereditary disease.—*Le Progrès Médical*, Nos. 44 and 47, 1877, and Nos. 1 and 4, 1878.

**Ulcerative syphilis in an infant.**—DUJARDIN-BEAUMETZ exhibited to the Société Médicale des Hôpitaux some pathological specimens from the body of an infant 14 months old, dead eight days. Reddish maculæ had appeared over the thighs, which soon became profound ulcers. Similar lesions invaded the velum palati. There had been no precedent signs of syphilis, and the infant died ten days after admission to the hospital. The autopsy had been conducted by Parrot, and the examination revealed the fact that death had resulted from an acute ulcerative syphilide. The reporter concluded by formulating Parrot's well-known views respecting the presence of osteophytes in bone syphilis of infants.—*Gazette Obstét.*, July 5, 1878, p. 205.

**Nervous lesions in congenital syphilis.**—DOWSE expressed his belief in the fact that many cases supposed to be strumous were really syphilitic, as the changes produced by congenital syphilis in the nervous centres had only lately received recognition. He narrated the case of a fairly-well-nourished, twelve-year-old girl, one of four living children, of whom none were healthy. There was a history of paternal syphilis. The mother had miscarried several times, and three of her children were reported as dead in infancy of phthisis. The patient was healthy till the fifth year, then had ophthalmia and ozæna, and, in 1872, a fit with four hours of unconsciousness. An ulcerative tubercular syphilide then affected the side of the nose, destroying the tip. Headache, diplopia, swelling of the optic disks, and epileptiform seizures followed, also anosmia, left facial anaesthesia, and paralysis of the right sixth and left seventh nerves, the third and fourth remaining unimpaired. Death occurred after several epileptic attacks, in which the right side was more involved than the left. Towards the close of life she became aphasic, and there was some paralysis of the right arm. Adhesions existed between the dura mater and surface of the brain in the parietal regions, and there were gummata in the upper part of the superior parietal lobule, and, on the left side, on the posterior parietal lobule and the supra-marginal gyrus. The arteries at the base of the brain presented endarteritic changes, as described by Heubner, and the

left fifth and seventh nerves were thickened, swollen, of a deep-pink color, and tough gelatinous texture. The liver and kidneys were lardaceous.—*Med. Examiner*, Feb. 21, 1878, p. 158.

**Hereditary syphilitic deafness.**—Mr. GEORGE P. FIELD, of St. Mary's Hospital, reports the case of a girl, 16 years of age, one of a family of eleven, nine of whose brothers and sisters died before attaining the age of four months. Three years previously she had an inflammatory affection of the eyes, soon followed by ear-disease. Her teeth were jagged. The tuning-fork was heard very indistinctly for a short time, and the watch only when in contact with the ear. Hopeless deafness supervened.—*Med. Times and Gazette*, Feb. 16, 1878, p. 168.

**The liver in hereditary syphilis.**—In the liver of the boy whose case is reported by Ross there were six gummata of moderate size.—*British Med. Journ.*, May 18, 1878, p. 737.

**Syphilitic disease of the testes in very young children.**—According to HUTINEL, lesions of the testis in children affected with hereditary syphilis are rarely of such development as to be easily recognized during life. Less rarely affected than the liver, the testis is often invaded when the viscera are intact, and often unaffected when the osseous and hepatic changes are extensive.

The lesions are usually double; one gland may be manifestly hypertrophied when the other seems to be of normal volume, yet both in such cases are usually implicated.

The clinical importance of the lesion is great, since the testis is usually, when affected, tender to the touch, and may thus give a clue to other visceral manifestations of the disease. Besides, its enlargement is rare in children who are not syphilitic. If a cachectic child of an unhealthy appearance, or a fat baby with a waxy tint of the skin, has suspicious fissures about the mouth and anus, an eruption of a doubtful character about the thighs or the trunk, and with these has voluminous painless testicles as hard as ivory, it is not hazardous to pronounce it syphilitic. The scrotum is usually large and lax, the testicle large, dense, and heavy, often of the size of a pigeon's egg, but usually no larger than a nut. The hypertrophy affects exclusively the testicular mass, the epidermis remaining intact. Rarely, there is effusion into the tunica vaginalis,—the reverse of similar accidents in the adult. It is probable that in those who survive, impotence must result, as atrophy of the organ would follow. Possibly, also, the so-called congenital atrophies of the testis and arrests of development may be due to the same cause.—*Journ. de Méd. et de Chir. Prat.*, March, 1878, p. 122.

**Diseases of joints in hereditary syphilis.**—Dr. WILTSHERE exhibited a photograph of a five-months' old infant, affected with enormous enlargements of the shoulder, hip, and knee-joints. The swelling had occurred rapidly, and been followed by distinct fluctuation. There were anaemia, mucous tubercles of the anus, and facial

and other signs of hereditary syphilis. By the aspirator pus was withdrawn from the abscesses. Post mortem, epiphyseal separation was evident, an abscess in the liver from breaking down of a gummatous tumor, and complete disorganization of the affected joints.—*British Medical Journal*, May 18, 1878, p. 732.

**Heredity syphilis with osteitis and pulmonary infiltration.**—The patient, whose case was considered by Prof. JACOBI, was a nine-year-old girl, who, after her first year, had glandular lesions of the neck and throat, often resulting in abscess. Two years previously she had suffered from nasal catarrh, with discharge of pus, blood, and tissue débris, resulting in implication of the nasal bones and septum and consequent deformity. The mother denied syphilis, but had had six miscarriages (one at the eighth month, the others earlier), and one child, now dead, born at term. Stripped, the child was found to be emaciated, the veins of the neck prominent, thoracic percussion-dulness on both sides, most distinct over the lower part of the left lung posteriorly, and the upper part of the right lung anteriorly; over a great part of the chest there was diminished respiration, and rude breathing at the right apex. The area of cardiac dulness was much increased, extending farther to the right than normal; there was also increased shock, with the apex-beat nearer to the right than usual.

The lecturer diagnosticated a specific pulmonary infiltration and right cardiac hypertrophy, a condition not infrequently resulting in phthisis,—the form of phthisis in which mercury is beneficial. In selecting a remedy for the disorder, the mercuric bichloride was preferred to the mercuric iodide, as productive of less irritation of the alimentary tract.

[No mention is made of the condition of the teeth and corneæ of the patient,—a serious omission in establishing a diagnosis where there are distinct evidences of struma. As to the remedy preferred, the reader fails to discover which of the two iodides is designated in the comparison. Experience has failed to demonstrate that the mercuric bichloride produces less irritation of the alimentary tract than does the protiodide.—*REP.]—Phila. Med. Times*, Sept. 14, 1878, p. 582.

**Osseous lesions in hereditary syphilis.**—In MACNAMARA'S lecture we find the history of a two-months' old infant, who had suffered from snuffles and “roseola” of the chest and back since its birth. There was also “eczema” of the genital and anal regions, produced by the irritation of condylomata. Above the wrist-joints the bones of the forearms were enlarged; there were symmetrical nodular osseous projections above the olecranon, and similar excrescences on the outer femoral condyles of the size of a split horse-bean. There was enlargement of bone over the greater trochanter of the femur, and on the same side the lower end of the tibia and fibula were enlarged just above the ankle-joint. The child's mother was

in good health; she had been married four years, and during that time had had one miscarriage; this was the first living child. The husband had had pains in the bones and "ulcers" over his chest and legs.

In the case of the child, there was a constant rise of temperature in the evening. Under the influence of corrosive sublimate and potassium iodide the child so far improved in general health that, in six months, although puny, there were no evidences of syphilis.

The lecturer drew a very accurate and careful picture of the histological changes in bone syphilis of infants, duly crediting Dr. R. W. Taylor, of New York, with his valuable contribution to the subject, and suggesting that syphilitic epiphyseal changes, confined to the phalanges and other bones of the hand and foot, without other evidences of the disease, might be safely considered as due to tuberculous inflammation of the medulla,—a position which requires the support of clinical facts.—*London Lancet, Amer. Reprint*, March, 1878, p. 114.

**Syphilitic osseous lesions in a child four years of age.**—LANNELONGUE exhibited to the Société de Chirurgie anatomical specimens removed from the body of a child dead in its fourth year. The father had suffered from syphilis before its birth. The pathological history of the mother was obscure. The little patient had been admitted to hospital for a phlegmon on the internal face of the knee. There were also cutaneous and mucous lesions. Death had ensued from diphtheria, contracted in the wards.

Post mortem, the tibia and inferior maxilla displayed, over different points of the epiphyses, genuine exostoses; elsewhere were intra-osseous purulent foci. Over the left tibia an abscess, opening externally, had given origin to the phlegmon described above. In the centre of the upper tibial epiphysis was a purulent cavity which approached the diaphysis, the epiphyseal cartilage having been totally destroyed. The tubercle of Gerdy in part was mobile. The osseous cavity was in process of repair.

A similar abscess was discovered in the upper part of the ramus of the maxilla, which, during life, had produced a spontaneous fracture.

The reporter concluded that, apart from the nasal and cutaneous symptoms, the bone lesions had not assumed a form which could have ensured an accurate diagnosis during life. Thus, the suppurative tibial lesion did not suggest an ordinary osteo-periostitis, though the maxillary trouble might have given rise to a suspicion of syphilis. Other manifestations, however, were distinct, and, in particular, a deep ulceration affecting the parts in the vicinity of the ala nasi.

GUÉNIOT added that, in 1869, he had presented to the Society the first communication on the subject of diaphyseal suppuration in syphilis without attributing the lesions to the disease. In his case all the diaphyses had been involved, with the exception of the superior extremities of the two bones of the forearm. A layer of

pus separated the epiphyses from the diaphysis. Parrot's later investigations have since given to these phenomena an interpretation now universally accepted. Osseous lesions in infantile syphilis are invariably multiple.—*Le Progrès Méd.*, April 6, 1878, p. 263.

**Treatment of infantile syphilis.**—M. ARCHAMBAULT would treat the infant of parents both known to be syphilitic at the moment of conception, even though the former exhibited no symptoms of the disease; and would pursue a similar course if one parent only were infected (but in view of the fact that these infants often escape entirely, the practice can scarcely be called sound). The author would not delay treatment in consequence either of the tender age or cachectic condition of the child. So slight a trace of mercury is found in the nurses' milk that he does not favor relying upon medicament of the nurse, but would give mercury by the mouth in all cases where there is not gastro-intestinal irritation, and in the latter event would have recourse to the skin. He finds the potassic iodide answer well in ecthymatosus, tubercular, and osseous lesions, but that it is yet of limited value. Mercury is named as of greatest worth,—the sublimate in preference to calomel, and Van Swieten's liquid as the most useful preparation of the metal. This is administered to mother and child,—to the latter twenty-drop doses are given thrice daily,—and the liquid is employed also as a lotion for mucous patches of the lips, and as an injection into the nares, where these are obstructed by crusts. Archambault employs the potassium iodide in children of all ages, by administering at first one-grain doses and increasing the amount till a maximum of ten or twelve grains has been attained. Three months is stated to be in general the duration of the treatment, after which careful observation is requisite, lest there be recidives. The author recommends, also, smearing the nipple of the nurse with fat in order to prevent contagion [a result which, according to Fournier, is almost certain to follow in the face of all such expedients.—REP.].—*L'Union Méd. du Canada*, July, 1878, p. 309.

**Treatment in cases of congenital syphilis.**—M. J. SIMON reports two typical cases of infants affected with hereditary syphilis and treated with Van Swieten's liquid, in doses ranging from twenty to thirty drops daily, taken in four parts. Attention is called to the favorable results of treatment continued for a short time only in curable cases, as contrasted with the extended periods of treatment requisite in adults.—*L'Union Méd. du Canada*, May, 1878, p. 208.

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## REVIEWS AND BOOK NOTICES.

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*A Handbook on the Diagnosis of Skin Diseases.* By Robert Liveing, A.M., M.D. Cantab., F.R.C.P. Lond., Lecturer on Dermatology to the Middlesex Hospital Medical School, etc. Longmans, Green & Co., London, 1878.

In some respects this little duodecimo book of Dr. Liveing's, of 266 pages, is one of the most important works on dermatology which has been published in England in a long time. Its importance lies in the fact that it is an exposition of the status of dermatological thought as seen by one of the younger English workers in dermatology, who grasps with a considerable breadth the subject as developed in the various centres of medical study. We have read a very large share of the work,—all that pertaining to any doubtful or much-discussed subjects,—and cannot help feeling that Dr. Liveing has laid the foundation for a solid structure in this branch. Without desiring to be personal, much less egotistical, we cannot help feeling that American dermatology has of late years represented a more general and comprehensive study of this branch than that obtaining in other countries, each of the great centres, England, France, and Germany, striving independently and each in a rather different line to reach the pinnacle as leaders of dermatological thought, often far too much to the neglect of the work and thought of the others.

It must now be conceded that while a healthy rivalry is advantageous, a comprehensive knowledge of a medical subject can only be gotten by embracing the advances made on all sides, and the successful teacher of dermatology must be fully conversant with the progress made not only by those who have gone before him, but must also assimilate the labor and study of his contemporaries.

We recognize, then, in this little book of Dr. Liveing's an attempt to harmonize dermatological thought, to define as clearly as possible exactly what is understood by the terms in common use, to connect together the ideas on cutaneous pathology of various countries, and thus to clear the way towards lopping off the individual peculiarities of individual teachers which have been and are still attaching themselves to this branch, that thus in the end a basis may be reached upon which the dermatology of every country may stand.

Thus much has been said not in order to praise the work, but to direct the attention of workers in dermatology to the subject, and to the aims and desires above expressed, with the hope that, as the

American Dermatological Association will harmonize thought and opinion on this branch in this country, we may ere long have occasional conventions of an International Dermatological Association, which shall ultimately do much towards accomplishing the same for the civilized medical world.

We will now notice some of the merits and defects, as we regard them, of this book. The nomenclature is good, Latin terms being used with very few exceptions, and in the main they are terms well known and in constant use. We object to the attempt to revive the obsolete name porrigo in place of impetigo, also to the exclusion of morphœa as a disease distinct from scleroderma, the retention of the name elephantiasis Græcorum for true leprosy, instead of lepra as now commonly understood, and perhaps a few other matters. But these, as may be seen, are not very important items ; we believe that the author has not suggested a single new name or proposed any radical alterations,—certainly a great merit.

We cannot, however, endorse the classification which he puts forward, which, while it has but eight classes, has so many groups and subdivisions that the subject is not simplified thereby. The time has passed for individual authors to put forth entirely new schemes of classification, and as the general plan used by Hebra has been adopted in so many directions, with certain simplifications, we cannot but hope that dermatological writers will cease from innovations, and seek rather to simplify this.

A valuable feature of the book is the "reference to plates" at the end of the description of each disease, whereby the author connects his descriptions with the delineations of the Atlases of the Sydenham Society, Hebra, Fox, Wilson, and Cazenave. He might have included others with advantage, and the value of the book would have been heightened if reference had also been made to the wonderful collection of models in Guy's Hospital Museum.

There is a want of symmetry in the work which should be corrected in future. Some diseases have a clear and brief definition ; others are only described, and not always in the very clearest manner. In the main, however, the work is well written, and, as remarked at the beginning, is an important attempt at giving in a concise shape the status of modern dermatology as regards the naming and differentiation of diseases of the skin. Dr. Liveing is already favorably known by the four editions of his little book on the treatment of Diseases of the Skin, and by his Goulstonian Lectures, in 1873, on Leprosy, and we welcome this more complete presentation of the subject of diseases of the skin.

*Treatise on Diseases of the Skin for Practitioners and Students.*  
*Die Hautkrankheiten für Aerzte und Studirende dargestellt.* By Dr. Gustav Behrend, pract. Arzte in Berlin. Braunschweig, Friedrich Wreden, 1879. Pp. 569, duodecimo.

The author of this work frankly states in his preface that it was written at the suggestion of the publisher, and that in its preparation

conscientious use was made of the literature of the subject. As regards the latter statement, a comparison with the well-known book of Neumann reveals so many striking points of resemblance between the two, not only in the manner in which the subjects are treated, but in the opinions expressed, and even in the formation of sentences, that it is easy to form an opinion as to which particular work had been most freely used.

The classification followed is that of Hebra, and his views as to etiology and treatment are adhered to with considerable fidelity. The work is thoroughly German in inspiration and style, and but little credit is given to the writers of other countries for their contributions to the literature of the subject, beyond a few of the best known names of France and England. American dermatology is recognized only in the reproduction of the excellent picture of Dr. Ochterlony's case of molluscum fibrosum which appeared in the ARCHIVES OF DERMATOLOGY, vol. i. p. 303. The sections devoted to the pathological histology of the different diseases are short and concise, which adds to the thoroughly practical character of the work.

Of special interest are the remarks on cutis anserina, which, we are told with positiveness, is usually present on the bodies of suicides, but is never found on the bodies of those who have been murdered. The condition is found on the skins of those who have committed suicide by drowning, whether the water were hot or cold, and is never present on drowned infants, which proves that the psychical condition of the individual during the last moments of life was the efficient cause of the phenomenon.

As a systematic, thorough, practical compilation on the subject, the work can be highly recommended as of great value to the practical physician, for whose use it is especially intended. It is cheaply gotten up, and contains numerous typographical errors. W. T. A.

*Lectures on Syphilis of the Muscles. Leçons sur les Myopathies syphilitiques.* By Charles Mauriac, Médecin de l'Hôpital du Midi. Paris, 1878, Delahaye. Pp. 208.

About half of this work, which is a reprint from the *Annales de Dermatologie et de Syphiligraphie*, vols. vii. and viii., is taken up in a carefully-detailed description of the malady first described by Notta as a syphilitic affection of the biceps. Eighteen cases are brought forward,—nine personal. Notta believed the malady to be tertiary or intermediary. Mauriac thinks it most common between the sixth and the tenth month. Other flexors besides the biceps are occasionally involved, rarely, however, in the lower extremity. The extensors occasionally suffer, notably the triceps brachialis.

The affection is more often observed in light than in severe cases of syphilis, and is noticed in those individuals in whom pains in the muscles and fibrous tissues are common rather than in those whose joints become involved.

The cutaneous symptoms accompanying it are more often dry than ulcerative. Mauriac observed it more frequently on the left side (six out of nine personal cases). He could not satisfy himself as to any exciting cause. Occasionally the malady is bilateral, but in such cases it is of unequal intensity on the two sides.

It commences gradually and advances slowly. There is a gradual loss of the power of complete extension of the elbow, and if a forcible attempt be made to straighten the arm, an acute pain is experienced at the point of insertion of the biceps into the radius. Complete flexion of the arm is possible with all its ordinary strength. Sometimes the triceps becomes involved at the same time. In such case the elbow becomes fixed at a variable angle of flexion (muscular ankylosis).

The elbow-joint, the bursa of the tendon of the biceps, the skin, and the connective tissue in these cases are all normal, says Mauriac. The tendon of the biceps is shortened, hard, rigid, prominent. The muscular fibres producing a rigidity appear to be in a sort of semi-contracted state, increased a little by voluntary flexion or forced extension. The muscular fibres appear to be positively shortened, not sensitive to pressure. Sometimes there are dull nocturnal cramps in the muscle. The pain on forced extension is referred to the upper internal portion of the inferior tendon of the biceps. If the triceps is also involved, forced flexion develops another focus of tenderness above the olecranon. These tendinous points are generally sensitive to pressure.

Untreated, this malady lasts several months, occasionally several years, but the muscular structure does not seem to become notably altered. It generally gets well even without treatment. Occasionally, sharp remissions and prompt relapses are observed during the course of the malady. Mixed treatment is most effective.

Mauriac believes that the lesion is a hyperæmic myositis (sub-inflammatory).

Syphilitic myositis differs from simple myositis in coming on more gradually, with less pain, and in having no tendency to suppuration. A hard, diffuse subaponeurotic tumor occupies the muscle or tendon involved. Untreated, the new fibrous tissue contracts (sclerosis of the muscle), causing atrophy of the muscular fibres. Sometimes the new tissue becomes cartilaginous, or bone is developed in it. Such results lead to permanent distortion (syphilitic lumbago, torticollis, etc.). The aponeuroses become involved in these changes. The long muscles of the extremities are most apt to be involved, but those of the face, orbit, larynx, sphincters of the anus, and others may suffer.

The symptoms of syphilitic tenositis resemble those of myositis. Diffuse inflammation is here less common than circumscribed gummy infiltration. The largest tendons are most apt to be involved, as the tendo Achillis, biceps brachialis, triceps centralis.

The prognosis in syphilitic myositis and tenositis is more grave than for the congestive myositis (first described). Mixed treat-

ment, however, will sometimes cure apparently desperate cases of long standing (three years).

Gummy tumors of the muscles and tendons generally appear late in the disease. Mauriac has three cases, however, where muscular gummata came on early in syphilis,—three to five months. The prognosis of these myomata is good. They disappear by absorption and leave no trace.

Classical tertiary gummata, being better known, are more briefly considered. The statement that they do not occur in young people is ascribed to Nélaton.

E. L. K.

*Atlas of Skin Diseases, consisting of a Series of Colored Illustrations, together with Descriptive Text and Notes upon Treatment.* By Tilbury Fox, M.D., F.R.C.P., Physician to the Department for Skin Diseases, University College Hospital. Parts XIII. to XVIII. Lindsay & Blakiston, Philadelphia, 1876.

In notices of former parts of this atlas we have commented especially on the plates, which were reproductions from Willan and Bateman's Atlas. In these six concluding fasciculi there are but seven of the illustrations taken from Willan and Bateman; the remaining seventeen plates are original. They represent a number of varied diseases, which we cannot here dwell upon,—ichthyosis, rodent ulcer, keloid, parasitic diseases, acne, morphœa, leprosy, etc. One cannot help wondering, when looking at Dr. Fox's delineation of "his" dysidrosis, and comparing it with the representation given by Mr. Hutchinson of cheiro-pompholix in his "Atlas of Clinical Surgery," how the two pictures could possibly represent one and the same disease; and yet the patient who furnished the original for Mr. Hutchinson's picture was once under the care of Dr. Fox, and the disease was claimed by him to be a severe case of "dysidrosis." It would never be dreamed of from the pictures.

We cannot help feeling a regret as we come to notice the completing portions of this work that on the whole it is so extremely unsatisfactory as a representation of skin diseases as they are wont to appear on living subjects. The gross features are there, to be sure, but there is certainly a want of artistic work on the plates which strikes one forcibly wherever the eye turns, and, compared to other specimens of lithographic medical work done in England and America, they are certainly a failure; and, strange as it may seem, the reproductions of the plates of Willan and Bateman are not nearly equal to those of the original work, either as artistic productions or as representations of disease. It is a pity that Dr. Fox's good work in the letter-press should not be accompanied by more praiseworthy illustrations.

## MISCELLANY.

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### CLASSIFICATION AND NOMENCLATURE OF SKIN DISEASES ADOPTED BY THE AMERICAN DERMATOLOGICAL ASSOCIATION, AUGUST 29, 1878.\*

#### Class I.—Disorders of the Glands.

- 1. Of the SWEAT GLANDS.  
Hyperidrosis.  
Miliaria crystallina.  
Anidrosis.  
Bromidrosis.  
Chromidrosis.
- 2. Of the SEBACEOUS GLANDS.  
Seborrhœa: *a.* oleosa; *b.* siccata.  
Comedo.  
Cyst: *a.* Milium; *b.* Wen.  
Molluscum sebum.  
Diminished secretion.

#### Class II.—Inflammations.

- Exanthemata.  
Erythema simplex.  
Erythema multiforme: *a.* papulosum; *b.* bullous; *c.* nodosum.  
Urticaria.  
† Dermatitis: *a.* traumatica; *b.* venenata; *c.* calorica.  
Erysipelas.  
Furuncle.  
Anthrax.  
Phlegmona diffusa.  
Pustula maligna.  
Herpes; *a.* facialis; *b.* progenitalis.  
Herpes zoster.  
Psoriasis.  
Pityriasis rubra.  
Lichen: *a.* planus; *b.* ruber.  
Eczema: *a.* erythematous; *b.* papulosum; *c.* vesiculosum; *d.* madidans; *e.* pustulosum; *f.* rubrum; *g.* squamosum.  
Prurigo.  
Acne.  
Impetigo.  
Impetigo contagiosa.  
Impetigo herpetiformis.

#### Ecthyma. Pemphigus.

#### Class III.—Hemorrhages. Purpura: *a.* simplex; *b.* haemorrhagica.

#### Class IV.—Hypertrophies.

- 1. Of PIGMENT.  
Lentigo.  
Chloasma: *a.* locale; *b.* universale.
- 2. Of EPIDERMAL AND PILLARY LAYERS.  
Keraisis: *a.* pilaris; *b.* senilis.  
Callositas.  
Clavus.  
Cornu cutaneum.  
Verruca.  
Verruca necrogenica.  
Xerosis.  
Ichthyosis.  
Of nail.  
Hirsuties.
- 3. Of CONNECTIVE TISSUE.  
Scleroderma.  
Sclerema neonatorum.  
Morphoea.  
Elephantiasis Arabum.  
Rosacea: *a.* erythematosa; *b.* hypertrophica.  
Framboesia.

#### Class V.—Atrophies.

- 1. Of PIGMENT.  
Leucoderma.  
Albinismus.  
Vitiligo.  
Canities.\*
- 2. Of HAIR.  
Alopecia.  
Alopecia areata.  
Alopecia furfuracea.  
Atrophia pilorum propria.
- 3. Of NAIL.
- 4. Of CUTIS.  
Atrophia senilis.  
Atrophia maculosa et striata.

#### Class VI.—New Growths.

- 1. Of CONNECTIVE TISSUE.  
Keloid.  
Cicatrix.  
Fibroma.  
Neuroma.  
Xanthoma.
- 2. Of VESSELS.  
Angioma.  
Angioma pigmentosum et atrophicum.  
Angioma cavernosum.  
Lymphangioma.
- 3. Of GRANULATION TISSUE.  
Rhino-scleroma.  
Lupus erythematosus.  
Lupus vulgaris.  
Scrofuloderma.  
Syphiloderm: *a.* erythematous; *b.* papulosum; *c.* pustulosum; *d.* tuberculosum; *e.* gummatosum.  
Lepra: *a.* tuberosa; *b.* maculosa; *c.* anaesthetica.  
Carcinoma.  
Sarcoma.

#### Class VII.—Ulcers.

#### Class VIII.—Neuroses.

- Hyperesthesia: *a.* pruritus; *b.* dermatalgia.  
Anaesthesia.

#### Class IX.—Parasitic Affections.

- 1. VEGETABLE.  
Tinea favosa.  
Tinea trichophytina: *a.* circinata; *b.* tonsurans; *c.* syicosis.  
Tinea versicolor.
- 2. ANIMAL.  
Scabies.  
Pediculosis capillitii.  
Pediculosis corporis.  
Pediculosis pubis.

\* We print here the classification as sent to us on a card: the report of the committee which prepared it has not yet appeared. We trust and believe that this is but provisional, and that it will be the subject of changes before being finally adopted by the Association. We invite discussion on the subject, and hope in the next issue to comment on it in full, and to present again the one which we published nearly two years ago (vol. iii. p. 200), with the slight modifications which further study has seemed to render advisable.—EDITOR.

† Indicating affections not properly included under other titles of this class.

**Didactic lectures on dermatology in the University of Pennsylvania.**—Although Professor Duhring has given regular clinical lectures on dermatology in the University Hospital for some years past, yet there has never been given in Philadelphia, up to the present winter, any systematic instruction on this branch of medicine. At the request of the authorities of the University, Professor Duhring has consented to deliver a course of didactic lectures on skin diseases, and has already progressed so far as to have covered the subjects of anatomy, general symptomatology, etiology, pathology, diagnosis, treatment, prognosis, and classification. After the Christmas holidays, the specific diseases of the skin will be taken up in order. The lectures are abundantly illustrated by means of a collection of exquisite wax models, belonging to Professor Geo. B. Wood, and which have for many years awaited in the University museum the opportunity for usefulness which is now to be afforded them. In addition, Professor Duhring's very large private collection of plates, water-colors, photographs, etc., are employed in illustration.

**Lectures on dermatology at the New York Hospital.**—During the past two months, Dr. Bulkley has been giving a course of lectures on diseases of the skin to practitioners of medicine and students at the New York Hospital on Wednesday afternoons, at half-past two o'clock. The course, which, when completed, will consist of twenty-four lectures, aims to cover the entire field, treating of each disease in turn systematically, according to a classification, which is kept continually in sight, printed on large charts. The first portion of each lecture is devoted to clinical teaching from cases, as ordinarily practised; afterwards the various diseases are treated of in succession, illustrated by Dr. Bulkley's private collection of life-sized models, made by Baretta, of the Hôpital St.-Louis, in Paris, and by his very large private collection of colored plates, photographs, engravings, etc., and also by the blackboard. The lecture-room, holding about one hundred, has invariably been crowded, mainly by physicians.

**A monument to dermatology.**—Cleopatra's Needle, which has been successfully erected in London on the banks of the Thames, will long speak of the devotion to the interests of the branch of cutaneous medicine of Professor Erasmus Wilson, F.R.S., F.R.C.S., by whose munificence it has been brought from Egypt and reared in the metropolis. He has just paid Mr. John Dixon, who undertook the work, his check for \$50,000; and it is pleasant to think that the means of bestowing this and his other gifts have come wholly from the practice of his profession,—wholly from dermatology.

**Correction.**—In the last issue of the ARCHIVES, the formula proposed by Dr. Piffard for Asiatic pill was arsenious acid, two parts; black pepper, two parts; sugar of milk, seventy-eight parts. It should have been printed *twenty* parts of black pepper, making one hundred in all, each grain of which represents one-fiftieth of a grain of arsenious acid.

# ARCHIVES OF DERMATOLOGY.

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APRIL, 1879.

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## ORIGINAL COMMUNICATIONS.

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### A CASE OF ULCERATIVE SCROFULODERM.\*

BY ARTHUR VAN HARLINGEN, M.D.,

Chief of the Skin Clinic, Hospital of the University of Pennsylvania.

THE case about to be described is one to which I have been unable to find an exact parallel in the range of modern dermatological literature. It has therefore been noted with some detail, and I desire to make it known as a rare form of disease of the skin, without attempting to assign it a name or even to indicate its nosological position more closely than convenience of reference would demand. The history of the case is as follows:

Mrs. H. had been for some time a patient at the Dispensary for Skin Diseases, when on February 21 of the current year she was carefully examined, with the following result. She was an American by birth and parentage, 70 years of age, and came of a long-lived, and, so far as her knowledge went, a generally healthy family. She was married at 23, and her husband, who was always perfectly healthy, lived to the age of 60, dying finally of typhus fever. She had never suffered a miscarriage, but had given birth to eleven children. Of these, one died at the age of 22 years of some wasting disease accompanied by a cough, and supposed to be consumption. Another suffered while an infant with an ulcer upon the neck, extending around it, and gradually destroying the tissues underneath, until finally a blood-vessel was opened and fatal hemorrhage ensued, the infant being 9 months of age. A third died from some unknown cause a few hours after birth. It showed no eruption upon the skin. A fourth child died of whooping-cough within the first year. Seven children were living at the date of this

\* Read at the second annual meeting of the American Dermatological Association, at Saratoga, August 28, 1878.

account. Of these, one, a boy, suffered during youth with a white swelling, following a bruise upon the knee. This joint-trouble lasted for years, fistulæ forming about the knee from time to time and discharging pus. Subsequently a tumor, regarded at first as a large boil, made its appearance in the scapular region and went on to suppuration, not healing over again for several years. The other four living children were healthy. None of the family had ever suffered from skin diseases of any sort, nor had any suffered from glandular enlargements nor from ophthalmia.

The patient had always enjoyed good health and insisted that, were it not for the annoyance of her skin affection, she should consider herself a healthy woman. Other members of the family, however, gave a different account, and stated that she had fallen off greatly in health and strength of late. It appears certain, however, that up to her fiftieth year she was in the enjoyment of fair, average health; she had borne eleven children, had passed the period of the menopause without accident, and, with the exception of a certain difficulty in perspiration, had never observed any abnormal condition of the skin. It was at the age of 50, some twenty years previous, that the first symptom pointing to any alterations in the skin was observed. This took the form of gradually increasing roughness of the skin of the legs, which at first attracted but little attention, but gradually became more and more marked until it forced itself upon the patient's notice. At the same time there began to be observed upon the ankles, feet, and legs certain small, roundish, infiltrated, rough, dry, and scaly patches, light gray or faintly reddish in color. No fluid was ever secreted from these lesions, which seemed quite indolent, and gave rise to no itching, burning, nor other abnormal sensation. Beyond the fact that the eruption, though slight and without sensation, persisted through ten years, the patient had but a dim recollection of it. After enduring without much alteration for the period mentioned, the skin-trouble began to extend very gradually to the thighs and thence to other portions of the body, and at this time the patient began to notice a certain remission during the summer months. On the whole, however, the disease grew steadily worse from year to year. Six years ago the patient suffered from smallpox, subsequent to which the chronic eruption became still more marked than before, and it then began to itch, the patches here and there showing moisture and crusting. From that date, too, the progress of the disease became more rapid. About four years before it had begun to spread over the face, within the year previous, ulcers had formed here and there, some of which had healed again, while others had continued open. With the exception of severe itching, the patient had suffered no inconvenience from the eruption. Her general health was fair, her appetite good. She slept well. Her functions generally were performed normally. She was inclined to chilliness. Mentally the patient was extremely depressed, regarding herself a leper and an outcast.

The history of the case is to be noted as imperfect, and especially

with regard to the changing appearances presented by the eruption in its various stages. Unfortunately the patient, a very respectable woman, had been told several years ago by some physician that she suffered from leprosy. From that time her only thought had been to hide away all signs of the disease, to look at it and think of it as little as might be, and to banish, if possible, every thought of it, as a loathsome and disgraceful blight, and a similar feeling prevailed among the other members of the family,—a feeling quite unfavorable to the observation of any transitions and alterations which might have taken place in the different lesions.

On inspection the patient appeared aged even beyond her years, feeble, thin almost to emaciation, the skin everywhere falling in loose folds and wrinkles. Her hair, still quite thick, was perfectly white. A casual inspection of the surface gave the impression of a universally diffused affection of the skin, in various stages of activity or quiescence. Only the palms and soles and the tip of the nose appeared free. The prevailing tint of the integument was brownish-red, except upon the legs, where it was ashen gray. In most places it was rough and scaly. The active lesions were in great variety, presenting the form of erythematous or scaly patches, papules, ulcers, nodules, etc., as will be more fully described a little later. So multiform were the various appearances presented that it is extremely difficult for me to give a word-picture of them which will vividly set forth their aspect. Perhaps the best plan will be to take the various portions of the surface in succession, portraying the lesions shown upon each, and going more closely into detail with reference to those most characteristically developed in the different localities as these are described.

The scalp was not markedly affected, excepting over the left temporo-frontal region, where the skin was thickened, reddish, and covered with an abundance of fine scales. The left ear was infiltrated, red, and scaly, as if affected with lupus, while the right was whitish, shrunken, and semi-cicatricial, as if it had been the seat of former disease. The face presented a shrunken, senile appearance, the integument everywhere thickened and scaly, of a generally diffused orange-brown tint, drawn somewhat tensely over the malar bones, but hanging loose and wrinkled about the neck. It was almost completely covered by papular lesions of various size and irregular shape, not sharply defined but melting into the surrounding skin, indurated, brownish, or violaceous in color. Some of these lesions were on a level with the general surface, and were covered with thin, micaceous scales; others were elevated, but not abruptly. Some were fissured; others were moist and secreted a thin, sticky, serous fluid. In several instances suppuration had taken place in one or another of the lesions, and they were covered with a thick crust. The few lesions which were seated upon the nose were sharply defined, irregular in shape, and rose abruptly to the height of about two millimetres. They were firm, hard, smooth, violaceous, and showed (at the time) no indication of breaking

down. The tip of the nose, alone of all the face, was free of disease; it was pale, waxy, and covered with comedones. As the papular lesions upon the face were essentially the same as those shown on various other parts of the body they may be appropriately described at this point. They appeared everywhere to constitute the initial lesion of the disease: whatever modification this afterwards assumed, a papule—not inflammatory, but of new cell growth—seemed to show itself as the first manifestation of disease action. This papule, if its growth were followed from the beginning, was at first of pin-head to pea size, roundish, usually rising abruptly from the surface, without inflammatory areola, sharply defined, dusky-red in color with a tinge of violet, smooth, or covered with fine, thin scales. The papule was apparently quite independent of the hairs or glands; these certainly did not constitute centres of growth. Later several of these papules might unite to form larger patches, some of which were as much as two inches in diameter, still preserving their roundish character. The smaller lesions were sometimes umbilicated, the larger ones were generally quite smooth, no longer sharply defined and rising abruptly from the surface, but merging into it on every side. Though the general shape of the lesions was roundish, a considerable number in different localities tended to assume a crescentic form. The destiny of these lesions was twofold. Sometimes the epithelium covering them gave way, and the surface presented a moist, oozing, serous, sticky exudation, crusting pretty readily, but remaining in *statu quo* indefinitely when covered with a rag. These lesions showed on the removal of the covering a moist surface, bleeding from numerous minute points. I never saw any of these abraded patches which could be said to have entirely healed over. But the patient asserted that in the earlier history of the affection these lesions not infrequently terminated in a sort of resolution, shrinking and drying up, and leaving behind them large achromatous patches of skin, presenting nothing abnormal except their color, and having no cicatrical hardness. These achromatous patches could be seen everywhere, contrasting curiously with the general dusky color of the skin. In other times, however, as at the time of examination, the disease showed a more serious character. The patches which then, or subsequently, broke down, did not alone show an abraded surface, but seemed to disintegrate more extensively, becoming transformed into ulcers, and being constantly covered with thick, greenish crusts. Frequently these ulcers assumed a crescentic or annular shape; sometimes they would involve the entire patch of new tissue, presenting an appearance of high, everted edges, due to the profuse suppuration and prominent crust. Occasionally one of the diseased patches would heal in the centre while spreading upon the periphery, while, in some instances, the whole centre included within an annular ulcer would become necrosed and separate as a slough.

Such were the lesions alluded to as present upon the face, though at the time of the first examination they had not shown the more

advanced stages of destructive metamorphosis just described. To return to the general aspect of the disease. The skin of the neck was somewhat affected : it was thickened, infiltrated, of an indistinctly mottled, reddish tint, and was covered with a thin layer of powdery scales, but without well-defined lesions. The affection became more marked about the shoulders and scapular regions, where all these appearances were emphasized, and where, in addition, numerous coin-sized annular and crescentic patches of more actively diseased, frequently ulcerated, tissue could be seen. The skin here was markedly pruriginous, and between the lesions was rough, infiltrated, red, and scaly. At the date of first examination the surface of the anterior aspect of the thorax, though presenting the general appearance noted above, showed no active lesions. The abdomen and buttocks appeared to have been the seat of former disease, since they displayed large patches of abnormally-white skin, which was not strictly cicatricial, and which yet had evidently been at one time affected by acute lesions. Between the white patches the skin was pigmented, brownish, and somewhat scaly. The integument here was not infiltrated or thickened to any appreciable extent, either at the seat of the achromatous patches or elsewhere.

The thighs presented for the most part very much the appearance shown upon the back and shoulders, reddened, infiltrated, and scaly integument, strewn with patches of new cell infiltration and ulcers. Upon the outer surface of the left thigh, however, was a large, actively-diseased patch, of oval form and eight by ten inches in size, in which could be seen the disease process in every stage. In the centre the skin was nearly normal in appearance, but deeply pigmented. Around this was an annular area, about one-third of which was infiltrated, elevated above the surrounding skin, its surface quite flat, denuded of epidermis, smooth, red, shining, moist, and weeping slightly. The remaining two-thirds of the ring was occupied with irregularly-shaped ulcers, from the size of a pea to that of a half-dollar (3 cm.). The smaller of these ulcers were in active process of suppuration or were granulating, while one or two of the larger ones were covered with a thick, foul slough just separating at the edge. These were interspersed with irregular bands of cicatricial tissue, in some places forming, in others breaking down anew. Below the knees the disease diminished in intensity. The legs and feet were at this time less affected than any other portion of the surface. These limbs were emaciated ; the skin was ashen gray in color, not thickened nor infiltrated, very scaly, almost ichthyotic ; this condition extending on the extensor aspect of the leg down over the dorsum of the foot to the very toes. In this locality there were at the time of this examination no distinct patches of neoplastic infiltration, nor were there any ulcers. A few cicatrices could be seen upon the instep, with some patches of pigmented skin. The soles were quite unaffected. Upon the arms the disease was distributed in a manner quite similar to that observed upon the thighs, no peculiarity being noticeable excepting about the right elbow. The

hands, from the wrists, were almost entirely unaffected. Only a few pea-sized, red, infiltrated, and scaly patches could be seen scattered over the backs. The exception just mentioned in connection with the right elbow, refers to a mass of indurated and nodulated tissue, situated on the extensor aspect of the joint, quite different from that presented in any other part of the skin, about nine centimetres in length by six in breadth, quite movable over the tissues beneath, and composed of grouped or distinct nodules or tubercles, the size of a large split pea to that of a small hazel-nut. About the edge of the mass were a number of single tubercles of a similar character situated in the lower layers of the skin. These masses were pearly white in color, smooth, hard, and glistening. They contrasted strongly with the lesions displayed in other parts of the body. A few near the edge were beginning to suppurate like the papular lesions elsewhere.

With regard to subjective symptoms no burning, itching, or stiffness was observed in the lesions as a general thing. Some of the larger ones when they broke down and ulcerated seemed rather tender and painful, and, occasionally, shooting pains were experienced in the neighborhood of the large patch on the thigh. In addition, the infiltrated and scaly portions of the skin, where no active lesions existed, sometimes itched severely. Thus, on the back, extensive scratch-marks could be observed, while as soon as the patient's clothing was removed she began rubbing and gently scratching all parts of the surface. The lesions themselves, however, were certainly not pruriginous.

Such was the patient's condition on February 21, 1878. As her subsequent history showed, she had just at that time reached a stage in the course of the disease where its whole progress began to be accelerated, and its tendency toward an unfavorable termination began to be manifest. She had been taking for some time previously a bitter tonic, with small doses of mercury, and had been using preparations of tar externally. She was now ordered cod-liver oil, with extract of malt, and for external use a carbolic acid wash, together with an absorbent powder for the ulcers. On the 8th of March some improvement was noted. The sloughs on the thigh had separated, and the ulcers appeared to be nearly healed. There were still three somewhat deep, unhealthy-looking ulcers, with smooth, slightly everted edges, included within the large patch upon the thigh. Here and there over the body the patches of neoplastic deposit had begun to show signs of disintegration. During the month of March the patient's general health began to improve, but she no longer left the house, and seemed too feeble to care to move even from room to room. In April, however, she failed more decidedly. She now began to keep her bed, though not complaining of any pain or annoyance, excepting occasional severe pruritus or pain when the ulcers, now increasing in number, were cleansed. She felt feeble and listless. It became necessary to administer beef-tea and punch with the hope of stimulating her

flagging vital powers. On May 1 the following note was made: The patient is growing weaker. She no longer leaves her bed, is listless, drowsy, and indisposed to move or even to sit up. She suffers from constant chilliness. Her skin is hot. Pulse 92. Her appetite continues good. She suffers no pain. The condition of the skin is decidedly worse: a number of patches of infiltrated tissue have broken down and are ulcerating, and while a fallacious appearance of healing is presented here and there, it cannot be said that any of the ulcers have been entirely cured. The disease has, moreover, attacked a new locality. The soles of the feet, which have hitherto escaped, are now the seat of lesions of a different form from any hitherto observed. The plantar integument, which is pale and bloodless, but apparently healthy, shows two or three bullæ, about five millimetres in diameter, situated on an indurated, violaceous base, which itself is about twice that width and is not raised above the surface of the surrounding skin. The whole lesion is about the size of a three-cent piece. One of these bullæ has been ruptured, and the epidermis has become detached, leaving a shallow, crescentic ulcer. There is no sensation of annoyance connected with these lesions; the patient was unaware of their existence. A few days later a further examination showed what progress the affection had been making over the body. It was then noted as follows: A papillomatous patch has made its appearance in the skin over the left pectoral region, quite unlike any lesion present in other localities. It is roundish, between four and five centimetres in diameter, and rises abruptly from the surrounding skin to the height of five millimetres, without any areola. When taken between the thumb and finger it resembles precisely to the touch a piece of soft leather, and is quite movable on the tissues beneath. The surface of this growth is smooth, moist, of a yellowish color, and exudes a transparent, sticky fluid. When the rag covering it is removed the surface is seen to bleed readily from numerous minute points. It is quite smooth and level on top and around the border. There is no nodulation.

On this occasion Prof. Duhring, who examined the patient with me, was kind enough to excise a portion of one of the nodules from the elbow. This was examined microscopically, with results which will be recorded below.

On May 18, it was noted:—The palms, hitherto unaffected, are found to be the seat of pustules, a few of which can be seen, discrete, raised, without areola. In addition, there are several bullæ about the size of those noted upon the soles, but rising directly from the skin, near the middle of the palm, and without any infiltrated base or violet-colored areola. They are filled with a greenish, sero-purulent fluid. New bullæ, together with pustules, like those upon the palms, have, of late, appeared upon the soles. The patient is feverish, her skin is hot, her pulse quick and feeble.

From this time her progress from bad to worse was more and more rapid. She lay in bed fearing to move on account of the

stiffness of her joints, and because of the pain caused by disturbing the dressings. Her appetite, which had been good, now failed, and her rest at night was broken. The constantly increasing number of suppurating lesions caused a serious drain upon her vitality, and these sores were now so numerous that it was a matter of an hour or two simply to cleanse and dress them daily. It became evident that a fatal termination was to be looked for. On May 27, the following note was made :—The condition of the skin has changed decidedly for the worse. The papular lesions and infiltrated patches are breaking down everywhere and suppurating. The scalp is full of scales, but shows no distinct lesions. The integument of the face is decidedly more infiltrated and scaly, and new ulcerative lesions are daily showing themselves in this locality. A deep ulcer, suppurating profusely and covered with a thick greenish crust, has appeared upon the upper lip, and the eyelids are the seat of similar lesions which keep them nearly closed. The disease has recently made its appearance within the mouth. The tongue is somewhat swollen toward the tip; it is red, dry, smooth, and betrays to the touch a hard mass of infiltration which is beginning to break down upon the surface into an ulcer. The papillomatous patch, noted a week or two ago as having appeared over the left pectoral region, has now sunk to a level with the surrounding skin or a little below it and is suppurating freely. No marked change has taken place in the character or appearance of the lesions over the body and limbs, excepting that they are more numerous and break down more readily, so that many of them are covered with thick rupial crusts. Some are decidedly serpiginous. A few days after this, another note of the patient's condition shows the end approaching. She lies nearly comatose, only rousing to take food. The urine and fæces are passed into the bed. The odor of the suppurating sores has within the last few days become exceedingly offensive. The face is now a mass of crusts, some rupial and prominent, others depressed and covering deep ulcers which seem as if the skin had been scooped out. Such ulcers are those on the eyelids and upon the upper and lower lips, outside of the red portion. The lesion in the tongue is 2.5 centimetres in diameter, and the induration extends through the entire thickness of the member. It is situated in the centre, near the tip; the surface of the tongue is fissured, smooth, and shining. In the centre of the hard palate is a tumor the size of a hazel-nut, smooth and fluctuating, but not open upon the surface. There appears to be another similar lesion in the lower part of the pharynx. A few days after this note was taken the patient died, quietly, from exhaustion.

The autopsy was performed by Dr. Morris Longstreth, eighteen hours after death, with the following result :—The body was extremely emaciated. The general color of the surface was a peculiar orange-yellow. The skin had been washed immediately upon the patient's decease, so that no crusts now remained, but the ulcerative lesions could be seen scattered over the whole body from head to foot.

These were no longer deep-looking or scooped out, as many had appeared to be, but seemed nearly level with the general surface, reddish in color, and resembling the denuded cutis of a blister. They were of various dimensions, from small to large coin size, and of very diverse form. Some were round, others annular, others circinate or crescentic. Looked at from a little distance the surface presented a grotesquely figurate appearance, as if the skin had been everywhere tattooed in arabesque patterns. Those portions of the skin not actually occupied by lesions were covered with roundish, achromatous patches of various size, level with the skin. The intermediate integument was deeply pigmented. There were no cicatricial patches, excepting on the thigh. Here the large patch, described above, appeared to have scarred over to a considerable extent, the cicatrix being smooth and not fibrous. Two roundish ulcers, about seven centimetres in diameter, remained, however, on this patch, together with one or two small erosions. The lesion on the left pectoral region was level with the skin and partly cicatrized.

Of the internal organs those of the abdomen and thorax were alone examined. In the former a small amount of clear serum was observed; the peritoneum was normal. The spleen was very small, its capsule thickened in places, and on its surface were many white spots of small size as well as a few whitish nodules, two or three millimetres in diameter. On section the tissue showed no abnormal condition. The supra-renal capsules showed similar nodules. The kidneys were small, the cortex very much reduced in thickness, but otherwise not markedly abnormal. The liver showed considerable nutmeg congestion, with some increase of fibrous tissue, but otherwise was not diseased. The tissue of the pancreas appeared somewhat atrophied, but contained no abnormal deposit. The ovaries were normal, as well as the uterus. The bladder was normal, but numerous nodules the size of a small pea, some fibrous, but mostly calcareous, could be observed. The stomach and intestines showed nothing abnormal.

The lungs were well inflated; a few adhesions existed on the left side posteriorly, and there was considerable serum in the right pleural sac. The apex of the left lung showed several firm fibrous patches surrounded with condensed and pigmented lung-tissue, and containing calcareous nodules. There were a number of similar calcareous nodules in other parts of this lung. In the posterior part of the upper lobe was an infarction, the size of a walnut, which was undergoing central softening. The remainder of the lung was crepitant (excepting the base and posterior part of the lower lobe, which was congested), and it was rather dry and very anaemic and pigmented. The right lung showed similar appearances. The glands at the root of the lungs were enlarged, very dark-colored, almost black, and very firm in consistence. The pericardium was normal and the heart presented no anomalies, excepting that a firm, calcareous mass could be seen at the attachment of the anterior leaflet of the mitral valve, but mostly buried in the fibrous tissue of

the auriculo-ventricular ring. This encircled one-half the orifice and was equally well felt in the auricle and ventricle; but in the ventricle, behind the angle of the valves, it was exposed and its extremity projected as a rounded mass the size of a cherry-stone. There were two other similar masses of small size on the other side of the orifice. The aorta showed a small calcareous patch on the under surface of the arch.

The portion of skin excised some three weeks before the patient's death was placed in the hands of Dr. Longstreth, who prepared a number of admirable sections, examination of which showed the following appearances:—Under a low power a perpendicular section displayed the horny layer of the epidermis, quite normal in character but very much thinned. The mucous layer appeared to preserve entirely its normal structure and appearance. The various layers of the cells preserved their usual size and shape, showing no signs of pressure nor of infiltration with neoplastic matter. The outlines of the papillæ were distinctly and accurately marked, and the projections of the mucous layer dipping down between them were entirely normal in character. Coming to the papillary layer of the corium this was perceived to be infiltrated with small roundish cells to the exclusion of the normal constituents. Lower down this cell infiltration appeared still more extensive; the cells were crowded and heaped together, and it was not until the lower portion of the corium was reached that the connective-tissue bundles made their appearance among the cells. The maximum of infiltration appeared to subsist on the upper and middle layers of the corium. The infiltration was uniform. No "nests" or groups of cells could be seen. The specimen contained no sebaceous follicles nor hairs. The sweat tubes, of which portions could be seen here and there in some sections, did not appear to afford centres of diseased action. Some abnormal cells could be seen through their structure, but these were possibly adventitious, and they were certainly not numerous. With regard to the character of the cells, these were extremely minute, averaging  $\frac{1}{6000}$  in. (0.00424 mm.), or about one-half the size of the red blood-corpuscle. They were roundish and occasionally slightly elongated. Their contents were granular, coloring well with carmine, and they were provided with a single nucleus of moderate size. They did not refract light strongly. The cells appeared to be held together by a delicate stroma of connective tissue, and they did not become scattered under the pressure of the covering glass.

In considering the character and course of the disease above described, it is difficult to say which of the known affections of the skin it resembles most closely; for there are features which appear to separate it from any hitherto described. Beginning, in all probability, as a scattered papular or tubercular new growth, with the not very numerous lesions widely scattered over the body, pursuing a chronic course and tending for the most part to reabsorption without leaving a marked cicatrix, it is found after making slow

progress, with remissions for many years, to assume an almost malignant type. The lesions, which were papular or tubercular, become ulcerative, a strong tendency to disintegration ensues, ulcers of an almost rupial character, or sanious and indolent, are found as the results of some lesions, while in others the rapidity of the destructive metamorphosis leads to the separation of sloughs. Later, the disease attacks the mucous membrane; the lips, tongue, and pharynx become the seat of lesions, the rapid growth of which resembles that of syphiloma, or gumma, while their clinical features are quite different. Finally, the affection saps the patient's vitality and she dies of exhaustion. At the autopsy but little internal trouble is observed: that which is noted points to the deposition, at some period, of tubercle. In addition, the patient shows at least one enlarged cervical gland of long standing, and the microscopic examination of the skin lesion shows it to belong to the class of granulomata, small cell new growths. Separated from syphilis and lupus erythematosus by its clinical history, the only affection with which it would be likely to be connected would seem to be that recently described, by Bizzero and others, as *tuberculosis* of the skin. An examination of the various cases reported under this name during the past few years, shows that either the lesions were distinctly nodular in appearance, or that there were ulcers, like those of epithelioma, or in some other radical way the cases differed from the one just reported.

For this reason I am inclined to regard the case reported as one of a hitherto undescribed disease. As I do not feel prepared to offer any name for the affection, I have designated it an ulcerative scrofuloderm, more for the purpose of convenient reference than with any other view.

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#### PARAPLEGIA OCCURRING IN SYPHILITIC SUBJECTS.\*

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THE question will at once be asked, Why not entitle this contribution syphilitic paraplegia? I avoid this term for several reasons. In the first place, it is not very scientific, because the present tendency of nosology is toward an anatomical classification of cerebro-spinal diseases. The names of alcoholic, rheumatic, malarial, gouty, syphilitic, etc., paralysis must, I believe, ultimately pass quite out of use in everything but conversations and clinical conferences, where a certain latitude of expression is allowed, and where such terms may serve to sustain therapeutic teaching. In the second place, the relation between syphilis and an existing para-

\* Read before the New York Neurological Society, March 3, 1879.

plegia in a given patient is often a matter of great uncertainty. This important point will be illustrated in the course of my remarks. Third, a paraplegia which improves or disappears under the use of mercury and iodide of potassium, is believed by many to be syphilitic, whether the patient admit or deny syphilis; and this reasoning from therapeutics is, to say the least, very uncertain; there are reasons for believing it to be far from infallible. Fourth, there are no definite symptom-groups which inform us that syphilis has attacked the spinal apparatus.

For these reasons, I have a strong objection to the terms syphilitic paraplegia, syphilitic hemiplegia, syphilitic aphasia, syphilitic epilepsy, syphilitic sciatica, etc.

I shall first relate cases illustrating the condition usually known as syphilitic paraplegia, *i.e.*, examples of paraplegia occurring in syphilitic persons, and improving under mercury and iodide of potassium.

*CASE I.—PRIMARY SORE IN 1871; SECONDARY MANIFESTATIONS IN SUCCEEDING TWO YEARS; RAPIDLY DEVELOPED PARAPLEGIA IN 1873, ABOUT TWENTY-SIX MONTHS AFTER CHANCRE; COMPLETE RECOVERY. SEEN IN CONSULTATION WITH DR. CHARLES McBURNEY.*

Mr. X., a member of one of the liberal professions, aged 24 years, contracted what seemed to be a soft chancre in February, 1871. The sore was noticed five or six days after coition; it was punched out and perfectly soft. A number of other small sores appeared round about this one, and they all healed under simple dressings in about five weeks. Large glands were observed in the inguinal regions, but they never suppurated. About April 1, the patient not having had sexual intercourse meanwhile, a small vesicle was observed on the site of the healed ulcer. This burst and left a shallow ulcerated patch with very slight induration, which became covered with skin in about four weeks. At the end of April, patient had headache, febrile movement in the afternoon, languor and anorexia, and about May 1, a copious roseolar eruption showed itself. At the same time the cicatrix in the frenum preputiæ was felt to be marked; of the "parchment variety." The inguinal, posterior, cervical, and other glands were enlarged; the throat was engorged, and the tonsils slightly eroded. Under the use of mercury and Zittmann's decoction, etc., all traces of this eruption disappeared by June 1. Slight pharyngitis was the only symptom which persisted during 1871-72. A transient crop of roseola appeared in June, 1872, passing away without treatment. The winter of 1872-73 was passed without apparent ill health. In March, 1873, there occurred a severe nasal catarrh, causing deafness of left ear. About the same time a few blotches of eruption, coppery, serpiginous, slightly raised, and desquamating, appeared on forearms and thighs. There was, also, a feeling of malaise and giddiness, which was succeeded by an unsteadiness of gait, which persisted and became worse from day to day. It was most marked at night, and when the patient turned

his head. About the middle of April (1873), severe lumbar pain was experienced, and the legs felt weak and heavy ; the unsteadiness increased. On April 20, after exposure to wet, *marked paraplegia* was noticed. The legs were so weak that the patient had considerable trouble in going up-stairs to his room ; there was very severe backache ; and the penis and scrotum were the seat of a curious mixture of numbness and hyperæsthesia. A hypodermic injection of morphia was given. That night and the next morning no urine could be passed, and in forty-eight hours complete paralysis of the lower extremities existed, with the exception that the right foot could be moved a little. The whole of the lower extremities was numb and partially anaesthetic, and an examination with the hand showed the temperature of the paralyzed parts to be raised. Reflexes were normal, complete retention, severe constipation, and partial paralysis of the sphincter ani existed. The treatment consisted in iodide of potassium, blue-pill, and bichloride of mercury. Twenty grains of the iodide were tolerated after some days. In about ten days after beginning of this treatment (fifteen from beginning of paraplegia) improvement began, and was progressive. The right extremity gained power and sensibility more rapidly than the first. Enough mercury was given to affect the gums slightly. At the end of the first week in May, while taking only iodide of potassium in twenty-grain doses, patient began to crawl about on hands and knees, and soon after stood with help. Reflex excitability was then exalted. About the first of June patient could walk several hundred yards at a time with canes ; yet his bladder was still inactive, the catheter being required to empty it. Acute cystitis now occurred, and from that time the expulsive power of the bladder increased. Early in July the walk was quite good, and the bladder better ; still, the catheter was required to procure complete evacuation of urine, and when semi-distended squirts of urine would occur, necessitating the wearing of an urinal (reflex incontinence). Iodide of potassium taken most of the time in twenty-grain doses ; omitted occasionally, because of gastric catarrh. Improvement slow.

Dr. McBurney personally directed the treatment and the excellent management detailed above, having conferred with me on various occasions. At the end of July the patient came under my personal observation, and I saw more or less of him for several weeks. He had then an excitable bladder, with incontinence through spasm. His legs were strong, in the ordinary sense of the word, but they were unmanageable, because of stiffness. The reflexes were much increased, jerkings of the legs recurring at night, and a stiffness of the extremities setting in whenever he stood and tried to walk. This condition we now call tetanoid, or spastic, and I have recently referred to this case in connection with the general subject of tetanoid paraplegia.\* No note was made of the state of

\* Archives of Medicine, No. 1. February, 1879.

sensibility, but my recollection is that it was normal. Galvanism and some spinal depressants, as ergot, conium, bromide of potassium, were tried for several weeks without effect. Spontaneous (occasionally some iodide of potassium) improvement continued. The patient spent a couple of years in Europe and returned here perfectly well. He has since married and has had healthy children.

*CASE II.—PRIMARY SORE IN APRIL, 1875; POPULAR ERUPTION IN ONE MONTH; FRESH ERUPTION IN SEPTEMBER; PARAPLEGIA GRADUALLY DEVELOPED FROM ABOUT OCTOBER 8. IMPERFECT RECOVERY; DEATH FROM APOPLEXY; NO AUTOPSY.*

Mr. B., aged about 50 years, was seen in consultation with Dr. William Detwold on October 20, 1875. I learned that the patient had been infected in April of the same year, and that papular eruptions had appeared twice, as specified in the summary. About twelve days before the consultation, Mr. B. noticed difficulty in passing water, and in a few hours had retention, requiring the use of the catheter. Still went down town to business; and on the fourth day, while in the street cars, noticed numbness in feet, and had some difficulty in stepping. Since, gradual but steady development of paraplegia. Left leg was more affected both with numbness and paresis. Three days ago could stand with help of a chair. Constipation and retention have continued. The numbness has extended on the left side up to umbilicus; on right side to just below groin. Has had no spasm in paralyzed parts, but has felt a strong constriction about ankles. Limbs subjectively cold; has lost his feet a few times in the bed. No symptoms in the hands or head. No rise of numbness in forty-eight hours.

*Examination lying down.*—Patient can move ankles and toes, and bend knee a trifle on right side. On the left side he can only move toes very slightly. Sensibility much impaired on both sides for contact and pain; this dulness of feeling extends up to knee on the right, and up to umbilicus on the left side. Nowhere is there absolute anaesthesia; painful impressions retarded. Tickling soles produces decided involuntary movements, more marked in right extremity. Faradic current causes good contractions of all muscles. No cystitis. Some pain across the back, but this is probably due to efforts at sitting up. Was advised, rest in bed; mercurial ointment, grm. 8, to armpit every night; iodide of potassium, grm. 4, every night; and ext. ergot. f.d. (Squibb's), grm. 8, twice a day. Patient passes catheter himself.

*November 14.*—After the consultation a female quack took charge of patient, and used Baumscheit's instrument with croton oil over whole body, and put him on a starvation diet. Has grown much worse. Numbness extends to lower ribs, the constriction band (inconstant) is just below navel. Spinal epilepsy marked. Urine must be drawn off; when bladder is over-full dribbling takes place. Severe pricking is felt everywhere on lower extremities, and produces reflex movements. Light contact not perceived below tuber-

osity of tibiae; not well felt as high as seventh rib. Some redness of legs. A bed-sore has formed on right side of coccyx. Legs are completely paralyzed; cannot move toes. Ordered nutritious food and wine; urine drawn every four hours; red iodide of mercury, .004 grm., and iodide of potassium, .75 grm., three times a day, with 4 grm. of iodide at bedtime. Sulphate of quinia, .30 grm., before breakfast.

*December 11.*—Great improvement. Toes were moved a little voluntarily within four days after beginning of treatment. Sensibility increased everywhere; hardly any sense of constriction; feels as if a hand were grasping his left flank. Can raise right knee, and moves ankles and toes well. Muscles above knees are uniformly wasted; those below knees preserved. The wasted thigh muscles have lost, in some degree, their contractility to faradism. Bed-sore deep, but is healing under ice and ointments. Some pus in urine. Mercury was stopped on 6th, no salivation. Has lately taken 4 grm. of iodide of potassium four times a day, and .30 grm. quinia in morning. Is rubbed and faradized daily.

The subsequent course of the disease was not specially interesting. Improvement progressed up to a certain point, and at the time of his death by apoplexy (no autopsy) patient could walk across a large room with crutches, and could take steps if leaning on the back of a chair. Lying down he seemed to have the full use of his legs, and the muscular masses had become normal. Sensibility was nearly normal. The chief trouble was abnormal reflex action. The moment that the attempt to stand or walk was made, stiffness and adduction of the legs took place, or, in other words, a tetanoid state had developed. This is a condition which we now know to be not rare in myelitis of the dorsal region.

The treatment during nearly two years consisted in the administration of mercury, iodide of potassium, and tonics. The gums were several times slightly touched, and as much as 24 grm. of iodide were given per diem. Massage, faradism, galvanism, counter-irritations to the dorsal region were also employed. During the last few months of life the bladder emptied itself by reflex action, and the catheter was seldom employed.

*CASE III.—PRIMARY SORE IN 1868; CUTANEOUS SYMPTOMS IN TWO OR THREE MONTHS; NO TERTIARY SYMPTOMS. IN ABOUT TEN MONTHS RAPIDLY DEVELOPED PARAPLEGIA; PARTIAL RECOVERY.*

A. B., seen in 1873. Chancre appeared in the autumn of 1868, a week or two after coitus; was accompanied by non-suppurating buboes; healed in a month. In two or three months an eruption appeared upon the body; red patches with suppurating (?) centres, leaving slight scars. No ocular or pharyngeal symptoms; no tertiary trouble. During the spring of 1869 patient suffered from severe pain in the loins and both flanks, more marked at night. At the same time he felt generally ill, lost flesh, and vomited. On June 16, gave up work and lay in bed with an increase of pains.

On July 4, suddenly seized with retention of urine, which was relieved by a hot sitz-bath. Stepped out of the bath well enough, but the next morning discovered complete paralysis of lower limbs. Could not move a toe or pass urine; legs were very numb; he noticed neither pain nor jerking. The retention and complete paralysis lasted over a month, when he began to move his toes, and has since progressively improved. Catheter used for six weeks; then had incontinence, followed by semi-normal action. No marked spinal epilepsy, no bed-sore, constricting band, or affection of the eyes. Right leg has recovered more quickly than the left.

*Examination.*—While seated can flex and extend legs a few degrees. Lying down can raise feet from bed two and four inches. Striking knees produces slight clonic spasm (tendon-reflex not then known); the muscles of the thigh are tense. By the help of two sticks walks with a gait characteristic of paresis,—a true dragging walk, with some stiffness of thigh muscles (tetanoid state). Stands with little oscillation when eyes are closed. Sensibility of lower limbs is normal. Retains urine a few hours.

*CASE IV.—PRIMARY SORE AND SECONDARY SYMPTOMS IN 1864.  
IN AUTUMN OF 1869 PAIN IN RIGHT SIDE AND BACK; IN SPRING  
OF 1871 COMPLETE PARAPLEGIA; PARTIAL RECOVERY, WITH  
TETANOID CONDITION.*

J. R., a baker, 42 years of age, was a patient of mine in the Hospital for the Paralyzed and Epileptic on Blackwell's Island in 1871-73. He admitted great sexual excesses, and stated that in 1864 he had contracted a chancre, which was followed by distinct secondary symptoms. During the autumn of 1869 he suffered from pain in the right side, and later, in the back; pain made worse by motion. On March 6, awoke with both legs numb, and retention of urine. Was admitted into the hospital, having a paraplegia with numbness and excessive reflex action, and accompanied by a large sacral bed-sore. He could not move his legs in the least. Improvement began in July; noticed sensation of distended bladder; acquired some voluntary power over both legs. Improved much under hypodermic injections of strychnia; bed-sore healing. During 1871-72 used iodide of potassium in large doses. I was inclined to consider the paraplegia one dependent upon a syphilitic lesion of the spinal dura mater, causing pressure and irritation. Discharged in early summer of 1872, able to walk on crutches and gaining. Examined before leaving the hospital. In supine position voluntary movements of left lower extremity are very free; can raise left foot twenty inches, and right foot ten inches above bed. Strength at various joints (resistance to passive movements) normal. Much jerking and spasm in legs. Appreciates light contact and tickling, but does not localize impressions well. Sensibility to pain and temperature normal. Legs are numb (subjectively) below knees. Right tibia bears large nodes.

Re-admitted and examined in autumn of 1872. Walks with help

of crutches, or of a stick. Steps small, legs tend to cross one another (adduction), and the lower extremities are stiff. Great spasm noticed in legs at times, especially on standing. In supine position voluntary movements of left lower limb are normal in extent ; those of right are restricted. Resistance strength at knees normal. Reflex excitability increased, more on the left side. Co-ordination perfect. Sensibility preserved, except as regards tactile sensibility, which is much impaired in feet. When patient attempts to stand upon his bare feet the spasm is so great as to cause him to lose his balance. The urine is not retained, and does not dribble away, but when the desire to urinate is felt he must empty the viscus almost immediately, or the urine is forced out against his will. Is still improving under large doses of iodide of potassium. This case, published in 1873, in an essay upon "Tetanoid Pseudo-Paraplegia,"\* seemed typical of the tetanoid state, but it is also an interesting example of recovery from symptoms which are usually fatal.

These four cases, in spite of some imperfection in the record, present several interesting features.

In the first place, what had been the syphilitic manifestations prior to the development of palsy? All four men described chancres. In Case I. the Hunterian chancre appeared in the scar of a soft chancre about five weeks after coitus. Secondary symptoms were noted in all the cases. In Case I. there were roseola (eight or nine weeks after coitus), and diffused sore throat for months; renewed eruptions in second and third years. In Case II. it is stated that a papular eruption had appeared twice in the first five months. In Case III. an ulcerating eruption made its appearance in two or three months after the chancre. Tertiary manifestations occurred only in Case IV. (nodes on tibiae).

In the second place, as to the time when the symptoms of syphilis of the spinal apparatus set in. In Case I. the paraplegia set in about twenty-six months after the inoculation ; in Case II., six months after infection ; in Case III., in about ten months ; in Case IV., seven years elapsed. This irregularity is in accordance with general experience ; and there are cases on record in which the date of appearance of syphilis of the spinal cord and membranes was very much more remote from the infection.†

In the third place, as to the mode of onset of the paraplegia. It was ushered in by lumbar pains and by paresis in Case I. ; it was characterized by much numbness and developed rather gradually in Case II. ; it was sudden in Case III., after severe lumbar pains ; in Case IV. it was discovered one morning, after severe pains in right side and back.

In the fourth place, as to the characters of the paraplegia. Paralysis of the bladder was present in all cases. The retention appeared suddenly, but posterior to paresis of the legs in Case I. It preceded

\* Description of a Peculiar Paraplegiform Affection. Archives of Scientific and Practical Medicine, 1873, No. 2, p. 101.

† Zambaco, Affections nerveuses syphilitiques, p. 230, *et seq.*

the paralysis in Cases II. and III. In Case IV. it was noticed simultaneously with great numbness and weakness. This early appearance of vesical paralysis is, I think, not connected with the *nature* of the lesion, but with its *location*; it would indicate a lesion in the dorsal region of the cord.

The other symptoms and the course of the disease were so various, that all that need be said in this connection is that the attacks were all severe. Sensibility was affected more or less in all cases.

The reflexes were increased in Cases I., II., and IV.

In Cases I., II., and IV. the increase in spinal excitability was so great as to cause a tetanoid state, exquisitely marked in Case IV.\* Muscular atrophy was noted only in Case II.; it involved the muscles of the thigh in a diffused way, was accompanied by marked reduction of faradic contractility, and it was cured by treatment.

In the fifth place, as to the issue. A complete cure was obtained only in Case I., after several years of treatment and hygiene. Long after all truly paralytic symptoms had passed away, abnormal excitability of the cord troubled the patient. In the remaining cases remarkable amelioration was had; infinitely more than is possible in non-syphilitic cases of myelitis. In Cases II. and IV. large bedsores formed and healed under the appropriate local and general treatment.

In the sixth place, as to treatment. Nothing is said of this in Case III. In Cases I. and II. the true nature of the lesion was at once recognized, and both mercury and iodide of potassium were administered in accordance with present views, viz., the gums were only slightly affected by the mercurial, while the iodide was given in large doses, in enormous doses for a long time in Case II. Counter-irritation does not seem to have been employed. Galvanism and faradism and rubbing were used at times in Cases I., II., and IV. The early treatment of Case IV. is imperfectly recorded, but it is noted that he improved under hypodermic injections of strychnia (prescribed by Dr. M. Gonzalez Echeverria, then Visiting Physician to the Hospital for the Paralyzed and Epileptic).

I shall now submit to you a case of paraplegia in which it would seem as if a mistake in diagnosis had been made from too rigid a diagnosis of syphilis; *i.e.*, an unwillingness, on my part, to accept a history of chancres, with more than doubtful secondary symptoms, as a basis for the diagnosis of syphilitic paraplegia, so called.

*CASE V.—CHANCRE WHEN 20 YEARS OF AGE; DOUBTFUL SECONDARY SYMPTOMS IN SAME YEAR; DOUBTFUL CHANCRÉS AT 23, WITH QUESTIONABLE ERUPTION, SORE THROAT, AND PAINS IN SUCCEEDING THREE YEARS. APPARENT SYPHILOPHOBIA. EIGHT YEARS AFTER FIRST CHANCRE (1874) PARTIAL PARAPLEGIA CONSIDERED NON-SPECIFIC, YET CURED BY INUNCTIONS OF MERCURY AND BY POTASH.*

Mr. A., aged 28 years, was brought to me by his physician, Dr. George M. Schweig, in November, 1874. The following history

\* See Archives of Medicine, No. 1.

was related: The patient had been delicate, though fairly healthy, until twenty years old, when he contracted a gonorrhœa, which was cured in three or four weeks, without gleet. Three months later acquired a "chancre" on the root of the penis; nothing on glans. This "chancre" consisted of a scab and a subjacent sore large enough to admit the tip of the little finger; had no buboes. Shortly afterwards (sore having healed rapidly), had an extensive eruption, most marked on legs; it consisted in red, non-elevated spots, itching very much, lasting more than a year, and communicated to bed-fellows and to children. This skin disease was cured in 1867 by means of green soap and Peruvian balsam. The site of above-mentioned chancre opened five times spontaneously. In Cincinnati, during the year 1869, had some small sores on glans penis, which healed speedily after having been touched with nitrate of silver. In 1870 and 1871 was troubled with an eruption of pimples in the scalp, without loss of hair, and once had a slight sore throat. In 1870, and since, more or less "rheumatism." This consisted in quite severe pain in the top of each shoulder, and in the right elbow. In 1872 pain and weakness affected the lower limbs; the pain being in the knees, not in tibiæ. At one time he had an excruciating boring pain in the left knee, just inside of the patella. In that year, at one time, the left arm and right leg were weak. No pains in head, tibiæ, or ulnæ. No headache.

About eleven weeks before the consultation (August, 1874), there occurred sudden convergent strabismus of left eye, with diplopia. The convergence has persisted. In the last three or four weeks the left lower extremity, from the nates and groin downward, has been numb and subjectively hot. In last few days numbness has appeared in the right leg. Legs have become unmanageable; has fallen twice, once from jerking of the left leg. No jerking of limbs in bed. No shooting pains anywhere. Has normal sensation of shoes and of floor. Urine now flows slowly; he must strain to pass it. Once an involuntary escape of urine. Marked constipation. Memory not impaired. Marked failure of sexual power in last few months. Was married over a year ago; wife well, and has a healthy child.

*Examination.*—Patient is physically frail, and very nervous in manner; constantly dwelling upon syphilitic aspect of case. Exhibits internal strabismus of left eye; fundus of eyes normal, according to Dr. E. Gruening. No symptoms in upper extremities. Walks fairly well; no marked jerk; staggers off to right. Stands and walks well with eyes closed. Strength at knees normal. No scars of eruptions on head or body. No cicatrix on glans penis. Near root of penis is a soft, whitish scar the size of a pea, where the so-called chancre was. There are glands in the groins, but they are all below Poupart's ligament; none in posterior cervical spaces. No nodes anywhere; no marks in throat or on tongue. Dr. Schweig states that the electro-muscular reactions are excessive in the lower limbs. Has been repeatedly relieved of so-called "rheu-

matism" by means of iodide of potassium. Believing that Mr. A. has cerebro-spinal gummata, Dr. Schweig has given him iodide of potassium 3ij. per diem; a quantity which has not agreed with the patient. Inunctions of mercury recommended.

I was disposed to reject syphilis because of absence of secondary and tertiary symptoms, and because the spinal symptoms present indicated chronic disease of the spinal cord, as anomalous sclerosis of the posterior columns, or localized myelitis. Besides, there seemed to be marked hypochondriasis. I advised nitrate of silver internally, and sulphur baths. After I had given this opinion, I was told that two years previously (1872) Prof. Frerichs, of Berlin, had examined the patient and declared that he was not syphilitic.

A few days later the question of syphilis was submitted to Prof. Freeman J. Bumstead, who also decided it negatively. Dr. Schweig, about November 24, began the administration of strychnia and ergotine internally. In about six days he abandoned these remedies, and, confident in his diagnosis of syphilitic disease, applied mercury freely by inunctions, just touching the gums. Electric baths were also given, and on January 15, 1875, the patient was reported to me as about well.

Although I made my mistake in the comforting company of Frerichs and Bumstead, I have always felt that it was not wholly excusable. I should have been broad enough in my conception of syphilis to give the patient the full benefit of any doubt, and have advised the treatment which Dr. Schweig successfully carried out, in spite of the consultants. He certainly deserves credit for acumen and boldness in this case. Since that time I have repeatedly (more especially in cerebral cases) given mercurials and iodide of potassium to subjects with as incomplete histories of syphilis, often with success.

My last case is an illustration of another error in diagnosis; the opposite. This mistake is not, I fear, very rare.

*CASE VI.—EARLY IN 1876 A SMALL CHANCRE; ULCERATED SORES ON LEGS, AND SORE THROAT IN ABOUT TWO MONTHS. IN SPRING OF 1878 GRADUALLY DEVELOPED PARTIAL PARALYSIS. NO IMPROVEMENT UNDER MERCURY AND IODIDE OF POTASSIUM.*

Mr. L., aged 28 years, was brought to me for examination by my friend, Dr. Conrad, on September 14, 1878. The patient had enjoyed good health until early in 1878, when he contracted a small chancre on the glans. Period of incubation not known. Had no buboes. Two months later ulcerating sores appeared upon the legs, and left indelible coppery cicatrices. At the same period had some sore throat. Was treated by means of inunctions of mercury and by iodide of potassium. Never had headache, alopecia, or rheumatoid pains. Remained well until February, 1878, when slowness of micturition showed itself, and progressively increased. For several days there was no other symptom; at times almost had retention, and when straining much had what he calls "cramps" in the

lower abdomen. There also occurred progressive loss of virile power; no spinal pain. At the end of March, or early in April, a new symptom was noticed, viz., perverted sensation in the right crural region, viz., every touch (even of cold objects) seemed converted into an impression of heat; this without marked anaesthesia. About the same time paresis of the lower limbs, chiefly of right thigh, appeared, and has persisted. Has had no neuralgic pains in legs, no constriction feeling, muscular atrophy, or spinal epilepsy. Has noticed in last few days that he staggered when standing with eyes closed. General health good. No symptoms above waist.

*Examination.*—Nothing abnormal in head or in upper extremities. Legs weak, but patient can walk without a cane, dragging both feet, the right more. Closing eyes causes marked loss of equilibrium. Knee-tendon reflex extreme, the slightest tap producing fibrillary or fascicular contractions in both quadriceps. The reflex from skin of soles is, however, only normal or sub-normal. Epileptoid trepidation can easily be produced. Muscles and nerves respond well to faradic current. No atrophy. Sensibility seems normally acute in feet and legs; points of aesthesiometer being distinguished at 2 and 2.5 c. on soles. Pain is well felt, and sensations are well localized. The thighs are not anaesthetic, but on the right thigh is a large region in which cold impressions (drop of water or spatula) are felt as hot. This district includes the lower iliac region, the anterior portion of the thigh, and over the knee to tuberosity of tibia, the buttock, posterior aspect of thigh to upper part of calf. Adductor region normal.

*Diagnosis.*—Syphilitic myelitis dorsalis, perhaps gumma of the cord.

Advised biniodide of mercury in doses sufficient to slightly affect the gums; iodide of potassium in doses of .75 grams three times a day, increased gradually to 15 or 24 grams a day. Cautery to spine; rest. The course of this case has been eminently unsatisfactory, in spite of Dr. Conrad's intelligent care. The treatment was fully carried out during the autumn, and the patient was slightly salivated. I saw Mr. L. again on November 7 and 20. No improvement had taken place. Paresis, reflexes, and paresthesia of right thigh, as before. Bladder very weak. At times has had severe dull pain in both heels and soles, and a little in metacarpus on both sides. Although soles are not anaesthetic, patient staggers much when eyes are closed. Advised, abandoning specific treatment, to try ergot, belladonna, and more counter-irritation by actual cautery to spine. At last accounts patient's condition was unchanged. Never has sharp or fulgurating pains, no numbness or constriction bands. Walks with feeble, dragging gait. Enormous knee-tendon reflex and strong epileptoid trepidation. Muscles flabby, but not atrophied. Strength at knees seems almost normal when patient lies down. No ataxia.

I might add a very similar case seen with Dr. Satterthwaite, last summer, and treated by myself in the last two months, but refrain,

because of the length of the paper. Suffice it to say that, with a probability of syphilitic causation equal to that usually present, this patient was given mercury and iodide of potassium in large doses without material benefit. The case resembled the last one in being chiefly motor, but a trace of ataxia has appeared, and three attacks of sharp pain in the rectum have suggested anomalous sclerosis of posterior columns to my mind.

Case VI. may be allowed to pass almost without comment. I am not sorry that we gave the poor fellow treatment appropriate to syphilis; it might have cured him; it has done him no harm.

These six cases (and I might have added others) suggest several lines of thought, which I shall briefly follow:

Can we, at the present time, make a positive diagnosis of "syphilitic paraplegia"? I think not. The diagnostic argument is fragile, and includes the fallacies of coincidence, interrupted sequence, and of unknown factors. Prominent among the reasons given for such a diagnosis is the one that the patient has had syphilis. This, in view of the complexity of the morbid conditions which cause paraplegia, and of the fact that symptoms are usually (in the nervous system) caused not by the nature but by the location of a lesion, is wellnigh worthless. Of more importance is a reasoning by exclusion, demonstrating that the paraplegia under consideration differs in notable particulars from that caused by well-known lesions of the spinal apparatus. I think that it may be learned from the cases related, and from those recorded in books and periodicals, that paraplegia of syphilitic origin is often atypical. In some of my patients pain in the back or in the side was severe, and suggested a lesion of the bones or meninges. The co-existence of a cerebral lesion, as shown by palsy of the third or sixth nerve, or dementia, or recent epilepsy, would go far to establish the diagnosis. The age of the patient, adult life, is an aid.

It is proposed to settle this obscure diagnosis by reference, *post hoc*, to the results of treatment. One objection to this is the logical objection that it throws the diagnosis out of the proper time; it carries it forward to a time when the patient will not want it much; *i.e.*, when cured or permanently paralyzed. Another objection is that it is far from proven that no other than syphilitic affections are cured or benefited by mercury and iodide of potassium.

This last objection involves a question of so great medical and social importance, that I feel obliged to trespass a little longer on your patience to say a few words about it. It has happened to all of us, I dare say, to witness the cure of serious cerebral symptoms by the iodide of potassium in persons who denied having had syphilis, and who bore none of the marks of the disease. I have seen at least five such cases, and in several of these there could be no question of the patient's truthfulness. The conclusion drawn from such a reasoning is usually that the affection treated was syphilitic; that the patient has deceived either himself or us as to

infection. In the same way we are apt to argue about obscure symptoms which disappear under the use of quinia; they must be, they are, malarial. There was a time when I accepted this argument as valid, but in the last two or three years a doubt has grown up in my mind, and acquired strength by added experience. This doubt is partly the result of clinical experience, and partly from an invincible objection to the doctrine of specifics. I have seen cases of disease which I cannot say were syphilitic, get well under iodide; and, on the other hand, I cannot be persuaded that this medicine or mercury acts specifically upon the syphilitic poison, be it in the shape of a dyscrasia or localized in solid tissues. These medicines, and others, cure disease, it seems to me, by changing and increasing the nutrition of the tissues, or by modifying the action of the nervous system, or by changing the chemical properties of the blood.

The treatment of paraplegia, which is supposed to be caused by syphilis, should be very energetic. The subject should, as soon as possible, be placed under the influence of mercury, by what method matters little. If the digestive organs are in good order I give the medicine by the mouth, guarded by opium, if necessary. The proto-iodide, the iodide, the two chlorides, and blue mass seem to be sufficiently good in proper doses. When there is doubt as to the strength of the digestive organs, it is better to use inunctions of ungt. hydrargyri or of the oleates. This treatment alone may do good, but it is to be aided by the simultaneous use of the iodide of potassium, given according to the American method, viz., fearlessly in doses gradually raised from 2 grams to 24, or even 32 grams a day. When largely diluted, this seldom disturbs the stomach; much less often than most practitioners think.

Important points in the treatment of severe cases are:

1. To keep the bladder empty, and to prevent or reduce cystitis. This is to be done by removing the urine two or three times a day by means of perfectly smooth soft catheters, which are to be kept in carbolized water when not used. It is probable that some cases of cystitis arise by the introduction of bacteria into the bladder by dirty catheters. If cystitis exist, injections of lukewarm water, of borated, or carbolized water will do good, or even cure the disease.

2. To prevent bed-sores, by keeping the sheets and shirt of the patient perfectly smooth and taut; by preventing urine from running under him; by frequent sponging with alcohol and water, and by the use of powders. If bed-sores have formed, they should be treated by ice or snow poultices for ten minutes twice a day, and stimulating dressings during the rest of the time; all gangrened shreds should be picked out, and the recesses of the sore injected with strongly carbolized water. Pressure should be removed by change of posture and by appropriate pads.

In the stage of recovery the iodide of potassium may be employed in moderate doses continuously or intermittently. An occasional week of mercurial may also be of benefit. Tonics are often called

for, and among the best is cod-liver oil. The muscles may need massage or electricity. The patient should be made to sit up in a chair, and try to walk as soon as possible.

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ON THE NOMENCLATURE AND CLASSIFICATION OF  
DISEASES OF THE SKIN: WITH REMARKS UPON  
THAT RECENTLY ADOPTED BY THE AMERICAN  
DERMATOLOGICAL ASSOCIATION.

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TWO years ago the writer published in this Journal\* a nomenclature and classification of diseases of the skin which had been used by him in teaching, believing that it presented the subject in a more concise, clear, and practical manner than had been previously accomplished. As it rested upon the basis of modern developments in dermatology, and agreed in the main with that accepted by many modern workers and writers, it was thought that this general plan was likely to be accepted and used, and that it possibly would form the basis of an universal scheme whereby the dermatology of various countries would unite in a common understanding.<sup>†</sup>

To this end no innovations were attempted, but, to quote what was said in the former article, "The present classification is based, as will be seen, largely upon that of Hebra, the main principles of which have stood the test of nearly a quarter of a century of hard work and active criticism, and which is to-day the accepted guide of many teachers in this and other countries. In preparing this nomenclature and classification, however, I have taken advantage of suggestions from Neumann, Duhring, and others, including French and English writers; and while the elements of the German arrangement of Hebra predominate largely, his arrangement will be found to be greatly modified and simplified, so as to form really a new one, which may properly be called an American classification, for use in studying and teaching dermatology in this country. It is not presented as a classification which we should wish to adopt as a final one, but it is offered as a report of progress, representing, as I conceive, the present state of opinion of the greatest number of those

\* Archives of Dermatology, Vol. III. p. 200, April, 1877.

† It is no little pleasure and satisfaction to find that in the recent clinical treatise on skin diseases, by Dr. Engelsted, physician-in-chief of the general hospital in Copenhagen, and well known as a writer on skin and venereal diseases, the classification and nomenclature here presented has been adopted, the author mentioning the fact in the preface, with the statement that he regards it as the clearest and best of the systems with which he is acquainted. This is a step towards the introduction of an universal nosological basis of dermatology.

who are, from clinical experience, best able to judge of the requirements and proprieties of a nomenclature and classification of diseases of the skin. This scheme is open to criticism, I am well aware, and I am also open to conviction in regard to any of its elements, and expect to make such changes in it in the future as advancing studies in dermatology will show to be advisable."

This scheme is now presented again, with the revisions which have seemed proper, after two years' further occupation in cutaneous medicine, and after much study and thought on the subject of its nosology, and after almost daily employment of this nomenclature and classification in teaching; attention will be called later to the points in which it has appeared best to make alterations or additions, which are indeed but few.

#### LESIONS OF THE SKIN.

##### A. PRIMARY LESIONS.

1. Macula; spot, macule.
2. Papula; papule.
3. Vesicula; vesicle.
4. Bulla; bleb.
5. Pustula; pustule.
6. Pomphus; wheal.
7. Tuberculum; tubercle.
8. Phyma; tumor.

##### B. SECONDARY LESIONS.

1. Squama; scale.
2. Crusta; crust.
3. Fissura; fissure.
4. Excoriatio; excoriation.
5. Ulcus; ulcer.
6. Cicatrix; scar.

#### CLASSIFICATION

OF

#### DISEASES OF THE SKIN.

##### CLASS I. Morbi cutis parasitici. Parasitic Affections.

- " II. Morbi glandularum cutis. Glandular Affections.
- " III. Neuroses. Neurotic Affections.
- " IV. Hyperæmiæ. Hyperæmic Affections.
- " V. Exsudationes. Exudative or Inflammatory Affections.
- " VI. Hæmorrhagiæ. Hæmorrhagic Affections.
- " VII. Hypertrophiæ. Hypertrophic Affections.
- " VIII. Atrophiæ. Atrophic Affections.
- " IX. Neoplasmata. New Formations.

##### Class I. Morbi cutis parasitici. Parasitic Affections.

- |               |                        |  |   |
|---------------|------------------------|--|---|
| A. VEGETABLE. | 1. Tinea trichophytina | } corporis (or tinea circinata).<br>(or trichophytosis) } capitis (or tinea tonsurans).<br>(parasite— <i>Tricho-</i><br><i>phyton tonsurans</i> ) } barbæ (or sycosis parasitica).<br>} cruris (or eczema marginatum). |   |
|               | 2. Tinea favosa        |  | (parasite— <i>Achorion Schänleinii</i> ). |
|               | (or favus)             |  |   |
- 
- |               |                     |   |
|---------------|---------------------|---|
| A. VEGETABLE. | 3. Tinea versicolor | (parasite— <i>Microsporon surfur</i> ). |
|               | (or chromophytosis) |   |
|               |                     |   |

- B. ANIMAL.
- |  |   |                                |
|--|---|--------------------------------|
| 1. Phthiriasis<br>(or pediculosis)             | $\left\{ \begin{array}{l} \text{corporis} \\ \text{capitis} \\ \text{pubis} \end{array} \right\}$ | (parasite— <i>Pediculus</i> ). |
| 2. Scabies (parasite— <i>Acarus scabiei</i> ). |   |                                |

**Class II. Morbi glandularum cutis.** Glandular Affections.

- A. DISEASES OF THE SEBACEOUS GLANDS.
- |  |  |   |
|--|--|---|
| I. Due to faulty secretion or excretion of sebaceous matter.         | $\left\{ \begin{array}{l} 1. \text{Acne sebacea} \\ 2. \text{Acne punctata} \\ 3. \text{Acne molluscum} \end{array} \right\}$                | $\left\{ \begin{array}{l} \text{oleosa} \\ \text{cerea} \\ \text{cornea} \\ \text{exsiccata} \end{array} \right\}$ (or seborrhœa).<br>(or xeroderma). |
| II. Due to inflammation of sebaceous glands with surrounding tissue. | $\left\{ \begin{array}{l} 4. \text{Acne simplex (or vulgaris).} \\ 5. \text{Acne indurata.} \\ 6. \text{Acne rosacea.} \end{array} \right\}$ |   |
- B. DISEASES OF THE SWEAT GLANDS.
- |                                   |   |  |
|-----------------------------------|---|--|
| I. As to quantity of secretion.   | $\left\{ \begin{array}{l} 1. \text{Hyperidrosis.} \\ 2. \text{Anidrosis.} \end{array} \right\}$   |  |
| II. As to quality of secretion.   | $\left\{ \begin{array}{l} 3. \text{Bromidrosis.} \\ 4. \text{Chromidrosis.} \end{array} \right\}$ |  |
| III. With retention of secretion. | $\left\{ \begin{array}{l} 5. \text{Dysidrosis.} \\ 6. \text{Sudamina.} \end{array} \right\}$      |  |

**Class III. Neuroses.** Neurotic Affections.

- 1. Zoster (herpes zoster or zona).
- 2. Pruritus.
- 3. Dermatalgia.
- 4. Hyperesthesia cutis.
- 5. Anesthesia cutis.
- 6. Dystrophia cutis (or trophic disturbances).

**Class IV. Hyperæmiæ.** Hyperæmic Affections.

- A. ACTIVE.
- |                     |  |
|---------------------|--|
| 1. Erythema simplex | $\left\{ \begin{array}{l} \text{idiotrophicum.} \\ \text{traumaticum.} \end{array} \right\}$ |
| 2. Roseola.         |  |
- B. PASSIVE.
- |                      |  |
|----------------------|--|
| 1. Livedo mechanica. |  |
| 2. Livedo calorica.  |  |

**Class V. Exsudationes.** Exudative or Inflammatory Affections.

- A. INDUCED BY INFECTION OR CONTAGION.
- |                           |  |
|---------------------------|--|
| 1. Rubeola (or measles).  |  |
| 2. Rubella (or rötheln).  |  |
| 3. Scarlatina.            |  |
| 4. Variola.               |  |
| 5. Varicella.             |  |
| 6. Vaccinia.              |  |
| 7. Pustula maligna.       |  |
| 8. Equinia (or glanders). |  |
| 9. Diphtheritis cutis.    |  |
| 10. Erysipelas.           |  |

B. OF INTERNAL OR LOCAL ORIGIN.	I. Erythematous.	1. Erythema      { multiforme. 2. Urticaria.      nodosum.
	II. Papular.	3. Lichen      { simplex. 4. Prurigo.      planus. ruber. scrofulosus.
	III. Vesicular.	5. Herpes      { iris. progenitalis. 6. Hydroa.      gestationis.
	IV. Bullous.	7. Pemphigus      { vulgaris. 8. Pompholix      foliaceus. (or cheiro-pompholix).
	V. Pustular.	9. Sycosis. 10. Impetigo. 11. Impetigo contagiosa. 12. Ecthyma.
	VI. Erythematous, papular, ves- icular, pustu- lar, etc.	13. Eczema. 14. Dermatitis      { calorica. { venenata. { traumatica.
	VII. Squamous.	15. Dermatitis exfoliativa (or pityriasis rubra). 16. Psoriasis. 17. Pityriasis capititis.
	VIII. Phlegmonous.	18. Furunculus (furunculosis). 19. Anthrax.
	IX. Ulcerative.	20. Ulcus      { simplex. { venereum. 21. Onychia.

### Class VI. Hæmorrhagiæ. Hæmorrhagic Affections.

1. Purpura. { simplex.  
              papulosa.  
              rheumatica (or peliosis rheumatica).  
              hæmorrhagica.  
2. Hæmatidrosis (or bloody sweat).  
3. Scorbutus.

### Class VII. Hypertrophiæ. Hypertrophic Affections.

A. OF PIGMENT.	1. Lentigo. 2. Chloasma. 3. Melanoderma.	4. Nævus pigmentosus. 5. Morbus Addisonii.
B. OF EPIDERMIS AND PAPILLÆ.	1. Keratosis pilaris (or lichen pilaris). 2. Ichthyosis. 3. Cornu cutaneum. 4. Clavus. 5. Tylosis (or callositas).	6. Verruca. { vulgaris. senilis. acuminata. necrogenica.
C. OF CONNECTIVE TISSUE.	1. Scleroderma. 2. Sclerema neonatorum. 3. Morphœa.	4. Elephantiasis (Arabum). 5. Dermatolysis. 6. Framboesia (or yaws).
D. OF HAIR.	1. Hirsuties.	2. Nævus pilosus.
E. OF NAIL.	1. Onychogryphosis.	2. Onychauxis.

**Class VIII. Atrophiæ. Atrophic Affections.**

- |                |  |   |
|----------------|--|---|
| A. OF PIGMENT. | { 1. Albinismus.   | 2. Leucoderma (or vitiligo).  |
|                | 3. Canities.   |   |
| B. OF CORIUM.  | { 1. Atropia cutis   | { propria.<br>linearis (or striæ atrophicæ).<br>maculosa (or maculæ atrophicæ). |
|                | 2. Atrophia senilis.   |   |
| C. OF HAIR.    | { 1. Alopecia.   | 2. Alopecia areata.   |
|                | 3. Trichorexis nodosa (atrophia pilorum propria, or<br>fragilitas crinum). |   |
| D. OF NAIL.    | Onychatrophia.   |   |

**Class IX. Neoplasmata. New Formations.****I. BENIGN NEW FORMATIONS.**

- |                                |  |                                     |                   |
|--------------------------------|--|-------------------------------------|-------------------|
| A. OF CONNECTIVE<br>TISSUE.    | { 1. Keloid.                               | 2. Fibroma (or molluscum fibrosum). |                   |
|                                | 3. Xanthoma (xanthelasma or vitiligoidea). |                                     |                   |
| B. OF GRANULA-<br>TION TISSUE. | { 1. Lupus                                 | { vulgaris.<br>erythematous.        | 3. Scrofuloderma. |
|                                | 2. Rhinoscleroma.                          |                                     | 4. Syphiloderma.  |
| C. OF BLOOD-<br>VESSELS.       | { 1. Nævus vasculosus.                     |                                     |                   |
|                                | 2. Angioma (or telangiectasis).            |                                     |                   |
| D. OF LYMPHATICS.              | { 1. Lymphangioma cutis.                   |                                     |                   |
|                                | 2. Lymphadenoma cutis.                     |                                     |                   |
| E. OF NERVES.                  | Neuroma cutis.                             |                                     |                   |

**II. MALIGNANT NEW FORMATIONS.**

- |              |                   |                               |
|--------------|-------------------|-------------------------------|
| 1. Lepra     | { tuberosa        | }(or elephantiasis Græcorum). |
|              | maculosa          |                               |
| 2. Carcinoma | { epitheliomatous | (or epithelioma).             |
|              | { papillomatous   | (or papilloma).               |
| 3. Sarcoma   | { idiopathic.     |                               |
|              | { pigmentosum     | (or melanosis).               |

But few points of difference exist between this scheme and that presented two years ago, and in no essential elements has it seemed necessary to alter either the classification or the nomenclature. Further study has demonstrated the advisability of adhering with absoluteness to the use of classical names, taken, as far as possible, from the Greek for primary terms, while for secondary names and expletives Latin is used. I am convinced of the very great desirability of writers in all countries endeavoring to follow this method, and of avoiding absolutely all local names, or those in the language of the writer, except as they are explanatory, or used as synonyms; only thus can observers in different countries make their work thoroughly available to those engaged in dermatology elsewhere.

The few changes which have been made in the classification are as follows: In the title of Class V., Exudations, the word "inflammatory" has been added, as more expressive of the class than simple "Exudative Affections." An addition of a group IX. of ulcerative affections has also been made to the second division of Class V., to include onychia and the varieties of ulcers. The reckoning of all ulcers under exudative or inflammatory affections is open to criti-

cism, inasmuch as the true syphilitic initial lesion has a neoplasm for its foundation; but, as the ulcerative process, or pus formation, is due to inflammatory action, they may, with propriety, be placed here. Finally, in Class IX., following the suggestion of the American Dermatological Association, I have used the designation "*Of granulation tissue*" in place of "*Cellular*," to designate the pathological condition in lupus, scrofuloderma, etc. The propriety of transferring syphilis or *syphiloderma* from this class to the group of exanthemata, Class V., placing it along side of scarlatina and smallpox, was seriously considered. It was thought best, however, for the present to retain it in its present position, although, as Mr. Hutchinson has pointed out, there are many points of resemblance which might justly place this disease among the group of specific fevers.

Another point of alteration has suggested itself, namely, the addition of a class or group to include what are known as medicinal rashes, such as those caused by copaiba, quinine, iodide, and bromide of potassium, etc.; but the subject has appeared to be not yet fully developed, and it was thought best to delay for the present any attempt to assign them any other place than such as the lesion present would give them, as, under erythema, urticaria, etc.

It will be unnecessary here to go over again the points mentioned in my former article, such as those in reference to the naming of the parasitic diseases, the grouping of the glandular affections and the neuroses, the position and relation of scleroderma and morphœa, etc., and I will simply mention the changes made or the new elements introduced.

The term *trichophytosis* is presented as a synonym of the trichophytic disease, as it has been used by several writers, and was adopted by the New York Dermatological Society to indicate this disease. *Chromophytosis* was also adopted by the latter in place of *tinea versicolor*, and as it is an euphonious word and characterizes in various ways the eruption, it may find favor, and is here suggested as a synonym.

In Class III. the term *zoster* is employed as quite as expressive as the longer word *herpes zoster*, while by disentangling the word *herpes* from this relation it can be more rightfully applied to the affections so called under Class V., which of course have no connection with the true inflammatory neurosis *zoster* or *zona*. Further thought has confirmed the propriety of the group of Neuroses in Class III., as previously explained: it is more than probable that this class will be added to very largely in future time, as researches demonstrate many diseases of the skin to be dependent upon a nerve causation, of which we already have so many intimations.

In the former classification, the only English name for a disease or lesion was found in this Class III., namely, "*trophic disturbances*," used to represent those changes in skin tissues resulting from nerve injuries. For these, following the formation of other dermatological names, the term "*dystrophy cutis*" is suggested.

In the heading of Class V., as previously mentioned, I have thought it desirable to add the word "*inflammatory*," instead of

speaking of this group of diseases simply as exudative affections, inasmuch as the latter term would signify to most minds an exudation on the surface of the skin, which does not exist in many of the diseases coming under this heading; whereas the term inflammatory undoubtedly expresses more correctly the pathological state in most of them. A possible exception to this may be found in the case of psoriasis, which recent investigations appear to show to be an ingrowth of the Malpighian layer, and not an inflammatory affection; but for the present the disease must rest in its former nosological position.

Under bullous eruptions I have introduced *pompholix*, as distinct from pemphigus and hydroa, to indicate the eruption which has been the subject of so much discussion of late, the cheiro-pompholix of Hutchinson, and some of the cases of "dysidrosis" of Fox, and whose pathology was discussed in a recent number of the ARCHIVES by Dr. Robinson. It certainly is a different affection from ordinary pemphigus, and I do not think the evidence adduced has shown the more severe cases to be a real dysidrosis, a disease of the sweat-glands (though I accept this name for certain cases, and it will be found in its proper position in Class II.). The term *cheiro-pompholix* seems less desirable than the shorter one adopted by Dr. Robinson, inasmuch as the affection is not one which is exclusively confined to the hands.

The term *dermatitis exfoliativa* has been here used in place of pityriasis rubra, it having found favor with writers, and being more expressive of the disease; also, as the word pityriasis is retained to be applied to the scaly disease of the scalp, distinct from seborrhœa, and also from psoriasis and eczema, it is well to have a distinct name for the more serious affection known as pityriasis rubra; also, the appellation dermatitis exfoliativa has been adopted by the New York Dermatological Society.

The synonym (or, rather, equivalent) *furunculosis* is introduced as indicative of the state of body in which furunculi develop. The separate lesion is a furunculus; but, as there is seldom a single one of these, the term furunculosis should come into more common use. The termination "osis" corresponds to that which is often employed to signify the state of affairs, and is seen in many dermatological terms.

*Melanoderma* has been added to Class VII., among pigmentary hypertrophies, to include certain anomalous cases of pigmentary disturbance which are continually occurring in practice, and of which there are a number of pictures extant in the Atlases, where the discolouration is more extensive than in chloasma, or of a peculiar and different distribution from that recognized under this term, generally also of a darker or different hue.

Hertofores there have been several quite distinct affections spoken of under the head of lichen. The American Dermatological Association has adopted the term *keratosis pilaris* in place of the old lichen pilaris, to indicate the epidermal hypertrophy which takes place around hair-follicles, and which is as far removed as possible

from the inflammatory forms of lichen. The innovation seems a good one, and is here adopted. *Tylosis* is here used in place of callositas, inasmuch as thereby may be included also those cases of epithelial hypertrophy of the tongue which have been described as *tylosis linguae*. *Verruca necrogenica*, indicating the warty growths which follow dissecting wounds, or poisoning with animal matter, having been omitted accidentally from the former classification, is here inserted in its proper place.

*Onychia*, as before remarked, has been taken from among hypertrophies of the nail (which it seldom is), and relegated to the fifth class of inflammatory affections, as ulcerative, which is nearer its true pathological and clinical situation. *Onychogryphosis*, the term used to designate an hypertrophied condition of the nails, whereby they become elongated and clawed or talon-like, appears in this scheme, it having been wrongly excluded from the former.

The subject of *atrophia cutis*, atrophy of the skin, Class VIII., has received much attention of late, and their varieties are not yet wholly clear; it appears best, however, to group them under three forms, the general atrophy, and that in lines and patches. Senile atrophy is reserved as a special affection, not included with the others.

*Trichorexis nodosa*, the name proposed by Kaposi for the peculiar swelling and fracture of the hair in minute nodosities, described by Beigel, Wilson, and others, under different names, seems so peculiarly appropriate and expressive, and has been accepted by so many observers in different nations, that it has won for itself a fixed place in dermatological nomenclature.

It is always desirable not to apply the same term, however it may be modified by expletives, to two afflictions of entirely different nature; we have therefore placed *fibroma*, Class IX., as the proper term to express the fibrous growths in the skin often known as *molluscum fibrosum*, or *molluscum pendulum*. This is sanctioned by many writers, whereas the word *molluscum* has been retained for, and will probably always cling to, the affection exhibiting sebaceous tumors, either those completely closed or those with an opening, known as *molluscum contagiosum*, or *molluscum sebaceum*, which in our classification are reckoned as *acne molluscum*, Class II. In regard to the true sebaceous nature of these latter, there has been, it is well known, considerable dispute during the past few years; the weight of evidence is again turning towards their sebaceous origin.

In the former scheme, three forms of true leprosy, *lepra*, or *elephantiasis Græcorum* were recognized; in the present but two, *lepra tuberosa* and *lepra maculosa*, are given; the third, *lepra anæsthetica*, is superfluous, inasmuch as both the preceding forms present anæsthetic symptoms, whereas it is doubtful if anæsthetic leprosy could exist without showing at some time either one or both of the preceding forms.

Finally, *melanosis* has been introduced as a synonym for pigmentary sarcoma, because, although any of the forms of cancer may also show pigmentation, in the destructive disease melanosis, as commonly

reported, the pigmentary deposit occurring in different parts of the body is commonly, if not always, found associated with sarcomatous elements.

As remarked before, and also on the publication of the scheme two years ago, this nomenclature and classification is not considered perfect, quite the reverse ; the subject is still one of much study, and many changes must result from further research, both clinical and microscopical, and it is earnestly desired that the subject shall be agitated and discussed until the dermatological thought of the world can be united upon a nomenclature based on a universal language, as the Latin (with the Greek), and on a classification which will in a measure group together diseases having points of similarity ; and thus, in a measure, can we bring order out of the chaos of diseases of the skin, without which the student, and also the medical man, may wander blindly in search of a correct diagnosis of the many forms of disease which attack this organ.

In the discussion which has occupied the New York Dermatological Society more or less for the past two years, the attempt at classification has been laid aside, and the subject of nomenclature alone has been under serious consideration and discussion before deciding upon the best and most feasible name to employ for each disease. This is perhaps a step in the right direction, for it is more essential to establish an uniform naming of diseases than an uniform grouping of them together. If the former is decided and acted upon in practice, matters will be much simplified ; members of the society, as well as the profession, will understand then what is meant by definite terms, and a few years will suffice to make the rising generation familiar with names which will then be employed with more definiteness than has previously been the case.

When printing the classification and nomenclature of skin diseases adopted by the American Dermatological Association,\* in the last issue of the ARCHIVES, discussion of the subject was invited, believing that further study and criticism would assist much in perfecting a scheme which could be given out to the medical profession of this country and other countries as the deliberate expression of the opinion of those devoted to this subject upon this very important matter. No discussion of it has yet appeared, and we cannot but pass a few criticisms upon it in hope of exciting further attention to the matter ; for, as remarked in the note appended to it in the last issue, "We trust and believe that this is but provisional, and that it will be the subject of changes before being finally adopted by the Association." The points now suggested may not all seem to be so very important, but the scheme should aim at being as perfect as possible, and it is in its details that the virtues or faults of such a work are apparent.

The main grouping of the classification happily follows that which

\* Archives of Dermatology, Vol. V., No. 1, Jan., 1879, p. 111.

is in common use by many, and little criticism is called for on its main divisions; it would, however, have been better to have given the names of the classes in Latin, indeed to have had even the subdivisions and the entire scheme expressed in this language, that it might be more intelligible to those of other nations engaged in dermatology.

Acne has been here excluded from the class of diseases of the sebaceous glands,—a very grave clinical error, as we regard it; for it is the commonest event to see the varieties of acne simplex, indurata, and rosacea associated with the sebaceous varieties, comedo, seborrhœa, and sebaceous cysts, whereas nosologically they are widely separated in this scheme, and the inflammatory forms are placed in another class of affections. Thus, as long as a sebaceous plug remains quiescent it is a comedo; when, however, its presence excites a surrounding inflammation, it ceases to be a disease of the sebaceous glands, and must be looked for under "inflammation," alongside of psoriasis, eczema, prurigo, impetigo, etc.

Coming now to this Class II., Inflammations, we find the "exanthemata" merely mentioned as a group, and then follow the names of twenty-two diseases, thrown together without order, with no subdivisions to indicate any differences between erysipelas and eczema, acne and pemphigus, prurigo and furuncle, pustula maligna and erythema simplex. The aim of a classification or arrangement of diseases, so as to be readily grasped, is surely not accomplished in this section. Herpes zoster is still retained in this division, although of all other diseases of the skin it stands out pre-eminently as a neurosis, whose nerve pathology rests on a very sure foundation. To place this among "inflammations," as though the inflamed condition of the skin were the most important element, is to violate the idea of a classification, which should of itself, as far as possible, suggest the nature and pathology of the eruption.

A curious foot-note appears appended to "*Dermatitis; a. traumatica; b. venenata; c. calorica,*" as follows: "\* Including affections not properly included under other titles of this class." We cannot understand its propriety or necessity. Simple inflammation of the skin, distinct from eczema, and excited by purely local causes, as traumatism, poisons, and heat and cold, is a constant clinical fact, a well-defined and perfectly-recognized condition; we do not see how it can include anything else or different, more or less, than is indicated by the name.

A very remarkable omission occurs in this Class II., namely, sycosis. This eruption, indicating a non-parasitic inflammation, affecting the hairy face, exhibiting pustules around the hairs, finds no place in the nomenclature under consideration. Recent microscopic investigation has demonstrated so clearly that this is a perifolliculitis, and clinical observation, in past and present time, has so firmly established it as a distinct disease, that the omission seems incomprehensible. Pityriasis capitis, a scaly disease of the scalp, quite distinct from seborrhœa, scaly eczema, psoriasis, etc., is also

excluded, nor does this eruption find any place in this classification ; and yet clinically it occurs and is recognized by many. Lichen simplex, as distinct from papular eczema, also finds no place here, whereas there exists little if any doubt as to the reality of the affection. The lichen scrofulosorum of Hebra is also excluded. Equinia or glanders is not mentioned.

In Class III., Hemorrhages, scorbutus has been excluded. If because it is not exclusively a skin disease, the same rule should apply to syphilis and leprosy. The skin symptoms are indeed well marked, and differ decidedly from those of true purpura, from which it is also distinguished completely by its etiology and treatment. No place is found here for haematidrosis or bloody sweat, nor does it appear at all in the classification, although a sufficient number of well-authenticated cases have been reported to give this peculiar condition the right of recognition.

Under Class IV., Hypertrophies, we have but two varieties of pigmentary augmentation noticed. The skin changes in Addison's disease find no place here or elsewhere, nor do either pigmentary or hairy naevi. Among hypertrophies of connective tissue we find "Rosacea : *a. erythematosa* ; *b. hypertrophic*." How we can have an *erythematous* hypertrophy is hard to imagine. While as a late secondary result in acne rosacea we may have an hypertrophied nose, even to great disfigurement, we regard it as a great error to attempt to force the diffusely-reddened acne rosacea from the group of sebaceous diseases, where it belongs, either to the class of inflammations or to that of hypertrophies. Clinical study shows daily the occurrence of the rosaceous alongside of the indurated and simple acne, and associated with the sebaceous forms of seborrhœa and comedo. We cannot deny that we frequently see a persistent, non-inflammatory erythema on the end of the nose or on the cheeks, unaccompanied by any immediate and acute signs of acne ; but if the case is carefully gone into, the history of acne is found, or if the patient is watched long enough it will develop. Moreover, it will be found that this reddened state of the surface is subject to exactly the same etiological conditions as acne, and that a constant and repeated flushing of the face from liquor, or dyspepsia, or other cause has resulted in the permanent defect (probably in vaso-motor innervation) which shows as a reddened surface. There is no proof that even any hypertrophied condition is a primary affair. Secondary effects should not be reckoned as separate diseases in a classification.

Under Class V., Atrophies, we have the two names leucoderma and vitiligo, which have always been regarded as synonymous, both appearing : albinismus also occurs, to indicate, we suppose, the congenital defect of pigment. We find also the term "*alopecia furfuracea*," used only by Hebra, and we presume therefore with his definition, namely, to indicate the state of chronic seborrhœa together with the gradual falling of the hair accompanying it ; we cannot see the propriety of thus placing seborrhœa in two classes, nor understand

wherein this alopecia differs from that intended by the simple term "alopecia" in the classification.

Among connective-tissue New Growths, Class VI., we find "cicatrix," a secondary lesion and not a disease; where an overgrowth of cicatricial tissue occurs all writers agree in calling it a keloidal growth, a false keloid.

Under the second division of this class, new growths of vessels, we find an entirely new name introduced, namely, "angioma pigmentosum et atrophicum," a name suggested at the same meeting by one of the members to indicate the disease which had been described by Hebra under the title "Xeroderma." While it must be granted that the latter name is entirely inappropriate, it seems hardly safe for the Association to put its stamp upon a new name for a disease about whose pathology and course we know so little. Angioma had already been given, probably as a synonym replacing the word nævus, which nowhere appears in this classification; angioma cavernosum follows, to indicate, we presume, deeper and larger blood-vessel new formations. In the New York Dermatological Society, the term nævus was retained for congenital vascular hypertrophy, and angioma was introduced to indicate an acquired dilatation of blood-vessels, to which telangiectasis had been formerly applied.

Lymphangioma here stands alone to represent lymphatic disease of the skin. Whether it is intended that this shall supplant the name lymphadenoma, already used by very many, we do not know; certain it is that this latter term is now well understood to represent a definite pathological lesion, described especially by several French writers. Kaposi suggested the term lymphangioma for a condition of the lymphatics resembling angioma or nævus of the blood-vessels, which he had observed in a *single* patient.

Under new growths of granulation tissue we find rhinoscleroma, lupus erythematosus and vulgaris, scrofuloderma, syphiloderma, lepra, carcinoma, and sarcoma. Epithelioma does not occur in the classification; it is intended, of course, to include this under carcinoma, but no such intimation is given, and those not well versed in dermatology might not understand it.

Class VII., Ulcers, we deem unnecessary; they can well find place, as before mentioned, in the class of inflammations, as ulcerative, together with onychia,—which latter, by the way, is not mentioned in the scheme before us. The only excuse for the class of ulcers is its adoption by Hebra; ulcers are generally secondary lesions, the result of previous pathological processes, and so far from being the basis of a distinct class, they can hardly claim the place we have accorded them, and would not, were it not for ulcers of the lower extremities, especially varicose ulcers, which often occur as independent affections, and demand very serious attention.

We have before noted the absence of zoster or herpes zoster from among the Neuroses, Class VIII., and have remarked upon the propriety of its standing as a typical neurosis. No notice is taken in

this classification of the skin lesions which are due directly to injury or disease of nerves; the trophic disturbances of the skin are now so well recognized that they should surely have a place in the nosology of this branch.

Hyperæsthesia is recognized simply as (*a.*) pruritus and (*b.*) dermatalgia. This we regard incorrect; instances are not at all uncommon in which we have an hyperæsthetic condition of skin where there is neither pruritus nor dermatalgia (pain in the skin), cases where it is simply exquisitely sensitive to the touch, while if left alone there is no pain as in true dermatalgia or neuralgia of cutaneous nerves. This condition exists not only in connection with certain nervous diseases but also apparently independently of central disease; the skin in a track of zoster is exquisitely hyperæsthetic.

The group of Parasitic Affections, Class IX., corresponds in the main with the arrangement commonly adopted, and there is little to suggest in its nomenclature or arrangement.

It would have added much to the utility of this scheme if certain synonyms could have been introduced; for, however clear the subject may appear to those whose thoughts are upon it more or less continuously, the employment of some terms which are not universally recognized nor commonly known must confuse those less familiar with the branch and who might look in vain for a name which they have been accustomed to use, and perhaps a name sanctioned by high dermatological authority.

In concluding this glance at the matter of the Nosology of Diseases of the Skin, we cannot forbear reflecting how much trouble and perplexity might have been avoided if writers in the past had been more content to adopt and use names previously suggested by others, and if they had avoided the serious blunder so often committed of attempting the formation of new terms and the distortion of old ones. While we must acknowledge that it is far better for a name to signify in itself the nature or cause of the disease, we cannot but deplore the fact that the continued innovations in Dermatology have caused the study of Diseases of the Skin to become such a *pons asinorum* to many, and the nomenclature and classification of this branch to become a by-word for intricacy and obscurity among the profession.

### ICHTHYOSIS HYSTRIX.\*

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**I**CHTHYOSIS is one of the rarer morbid affections of the skin, and is defined by Neumann as "a disease characterized by an accumulation of epidermal matter, hypertrophy of the papillary layer, and thickening of the whole corium, with an alteration in the

\* Read before the Medico-Chirurgical Society of Montreal, January 24, 1879.

cutaneous glands." The depositions consist of epithelial scales mixed with sebaceous matter, and "may be either white and of the thinness of paper, or dark-colored grayish-green, brown, or black masses, or horny spines and shields several lines in length, firmly attached to the subjacent sides, and which, in the normal condition, cause the furrows and lines crossing the epidermis to be rendered evident in a very striking manner." The disease may be limited to certain portions of the skin, or more commonly occupies the greater part of the surface; it is usually developed soon after birth, although it may in exceptional cases first appear after maturity is reached. It can rarely be cured, but usually persists during the whole life of the patient. The glandular secretion is deficient, so that the skin is harsh and dry, said to be due either to congenital absence or defective formation of the sudoriferous glands or to their early atrophy. Two varieties of this disease are usually distinguished,—ichthyosis simplex and ichthyosis hystrix. The first term is applied when the epidermal masses are thin and furfuraceous like bran, or thick, like fish scales; the earlier conditions of this variety, where the skin is harsh and dry, with only slight exfoliation of the epidermis, is termed xeroderma. Ichthyosis hystrix is applied to the most exaggerated condition of this disease, where large, thick, dark-colored masses are formed several lines in thickness, and standing out from the skin sometimes like quills on the back of the porcupine, hence the name; there is also a considerable amount of papillary hypertrophy. These varieties may occur independent of each other or together, they vary with the age of the patient, becoming more marked as adult age is approached. The color of the scales varies with the period of the disease; at first pale, it gradually becomes tawny, dark olive-green, and at last black, and is owing to dust and dirt becoming incorporated with the scales, fat, and sebaceous matter, more than to any pigmentary discoloration of the skin proper.

In whatever form the ichthyosis occurs it attains a certain degree of development in each particular case, and then usually remains unaltered throughout the patient's life. It is often hereditary, but not always, and although not regarded as strictly congenital, the predisposition to the disease, which develops later, is born with the individual. It is sometimes acquired in later life, appearing as patches on the lower extremities, the result of chronic eczema and varicose ulcers; when hereditary, it often affects the same sex through several generations.

The following case had not reached its full development, although it presents a well-marked instance of the higher grade of the disease,—ichthyosis hystrix,—and is interesting on account of the unusual manner in which the disease is distributed over the surface, and from its occupying certain localities usually thought to possess immunity from its attack.

Charles Satry, aged seven years and eight months, first came under my notice in the month of November last. He was born in Chicago, but during the last four years has resided in Montreal. He is the fifth

child of a family of nine, of whom three only are now living, all died at ages varying from two and a half months to two and a half years. The parents state that two died from some intestinal disorder, both having diarrhoea. From what I can make out, the disease was probably tabes mesenterica, two others had some affection of the head and died in convulsions, most likely tubercular meningitis, another died while teething, and the subject of the present paper died on the fifth of January of acute miliary tuberculosis. The parents are of French descent, both somewhat below medium height, and have enjoyed tolerably good health. The father states that several members of his family have died of consumption. The mother also states that she has lost a brother and sister, who were said to have died of consumption, she is at present herself occasionally affected with haemoptysis. They do not know of any instance in either family in which a skin disease occurred similar to that seen in this child, nor have they observed it in any of their other children. The mother states that at birth he was the largest and fattest of all her children, and showed no trace of anything unusual on its skin until he was about five months old, when she noticed a rough scaly patch on the right side of the back of the neck, which she thought was prickly heat; the patch was of a darker shade than the surrounding skin, and branched in different directions; at the end of a year it occupied more surface, and the scales were thicker and darker in color, especially in the centre of the patch. The skin now began to have the same appearance on the back, right side, and arm-pits, until at four years of age it existed on the thigh, groin, knee, ankle, and forearm of the right side; at this age it began to appear on the left side of the body, first on the chest and shoulder, and since then new patches have shown themselves, and existing ones are gradually enlarging. On parts exposed to much friction from the clothing the dark masses were being continually knocked off, but would soon again reform, and this process of shedding and being reproduced was frequently repeated. The child has, during the last four or five years, been in delicate health, always preferred remaining indoors, had a poor appetite, and bowels unusually constipated. He was a fat child until he was four years old, since then his health has been failing, and he has become wasted and pale. His skin was always dry; the mother states that she never knew any part of his body to show signs of sensible perspiration except his hands and feet, and the latter did so to an unusual degree, as she usually found his stockings quite damp on being removed. It was difficult also to keep his feet warm. He never complained of nor seemed to suffer from any irritation or other inconvenience owing to the disease.

On examining his body minutely, the patches were found to occupy the following positions. The face was free from the disease, the skin being soft and clear, and there did not appear to be any abnormal deficiency or subcutaneous adipose tissue; this condition was, however, present in a marked degree in the other regions of the body. The posterior and right side of the neck was almost entirely covered;

a large patch also occupied the front of the neck just over the thyroid cartilage. On the trunk a large patch is seen in the right axillary region, extending backwards over the scapula and posterior part of the shoulder; a long belt of the diseased tissue commences at the sternum near the fifth costal cartilage, passes outward along the intercostal space for a short distance, then descends obliquely to the seventh rib, where it turns upward and terminates at the lower end of the scapula. In the epigastric and lumbar regions a similar tract is seen. Commencing around the umbilicus, it passes obliquely upward to the lower margin of the ribs, and follows the direction of the ninth intercostal space towards the spine. The posterior extremities of these three patches on the trunk all coalesce a little to the right of the spine. One cannot fail to observe how closely the course of these tracts correspond with the distribution of the lateral cutaneous nerves.

Another deposit, remarkable on account of its narrowness, zigzag course, and the length and development of the hypertrophies, reminding one of a string of coral, begins at the linea alba, about midway between the umbilicus and pubis, passes to the inguinal region, crossing Poupart's ligament near its outer extremity, it then curves around below the anterior superior spine of the ilium, and passes backward towards the sacrum parallel with the crest of the former bone. On the left side a long narrow patch passes from the inguinal region over the crest of the ilium a little posterior to its anterior spine, and coils around towards the posterior spine; a patch is also seen in the left axilla, and two long patches exist on this side similar to those on the right; they follow the same course, but those on the thorax occupy a position about an inch lower than the corresponding patches on the opposite side. Those on the left side are less marked than on the right, owing to their more recent formation. On the right arm thickly set patches exist over the posterior part of the shoulder and pass into the axilla. On the forearm a narrow strip begins at the space between the internal condyle of the humerus and olecranon process of the ulna, follows the internal surface of the latter to the wrist, when it turns on to the back of the hand and terminates about the centre of the metacarpal bone of the middle finger, where it is joined by a similar branch coming from the radial side of the forearm. These patches almost exactly correspond with the distribution of the posterior branch of the internal cutaneous and the dorsal cutaneous branch of the ulnar on the inner side, and on the outer with that of the posterior branch of the external cutaneous and internal branch of the radial nerve; and the point of junction of the patches is at the same spot where the communicating branch from the ulnar joins and forms an arch with the internal branch of the radial. The left arm is affected at the anterior part of the shoulder, the patch being continuous with that in the axilla.

On the right lower extremity, patches exist on the inner side of great toe; on the second phalanx of third toe, along the metatarsal bone of which it extends for about half an inch; on the anterior part of ankle a large patch, and on the inner side of foot several

elongated lines. At the knee the whole anterior and inner aspect is involved ; a line extends from lower third of thigh over the inner condyle, behind a long narrow strip extending from the gluteal region down the centre of the thigh to the popliteal space, best marked at either extremity. This strip follows very closely the distribution of the cutaneous branches of the small sciatic nerve ; another patch, slightly developed, exists on the outer aspect of the thigh. Two fusiform patches, lying very close together, are seen in the right groin and upper third of the inner and anterior aspect of the thigh, and extending upward as a narrow prolongation over the lower part of the abdomen. The surface covered by them corresponds with that supplied by the ilio-inguinal and ilio-hypogastric nerves.

On the left lower extremity there is considerable thickening of the epidermis over the knee and instep. The scrotum also presents a large and well-developed patch on the anterior and lower surface of the right side.

(A sketch of this boy's body in different positions, pencilled and colored for me by Mr. Raphael, shows beautifully the appearance and position of the disease.)

The character of these patches varies on different parts of the body. The whole surface was unusually dry, but no perceptible furfuraceous desquamation could be observed between the patches except immediately around them. The patch on the left knee seemed to be just forming and would correspond with the variety of the disease known as ichthyosis simplex, where there is only a moderate accumulation of epidermal matter. It is grayish in color, rough, and covered with thin scales, detached to a greater or less extent at their margins. The skin is thickened and mapped out into irregular-shaped eminences, separated by deep furrows, which correspond with the normal skin lines. On the right knee and front of ankle the epithelial collection is very dense, dark olive-green and blackish in color, and has the appearance of large warts, some of them here are nearly two lines in thickness and one-third of an inch in diameter. These large dark incrustations are horny in texture, and of about the same consistence as a vaccine crust, and can be removed ; when picked off, the papillæ beneath are seen to be enlarged, dry, and shrivelled.

The patches on the neck and trunk present a somewhat different aspect ; here the accumulation is arranged as triangular, quadrangular, and polygonal projections two lines and over in length and much longer than broad, mostly blunt-pointed and fitting closely with each other like a number of little blocks standing on end, their sides being converted into smooth facets by movement and friction upon each other, all being closely compacted together, their extremities forming a tolerably even tessellated surface which is very dark in color. At the post-mortem examination a minute sketch of the patch of disease in the groin was secured, this being the only part of the body besides the scrotum in which the normal appearance of the affection had not been obliterated, owing to the profuse sweating which occurred during the child's illness, although the sketch rep-

resents faithfully the appearance at this point, it only feebly illustrates the condition which the disease presented on other parts of the body when I first saw him. The following histological description is by Dr. Osler, who performed the post-mortem:

Small bits of the crust-like exudation teased up in saline solution, show an unusual number of flattened scaly epithelial structures, together with dust-particles and oil drops. Cut sections through the whole thickness of the skin gave the following particulars: the epidermis in the diseased spots is enormously thickened, composed of stratified layers of epithelium pursuing a wavy course, and often projecting as pointed processes, which usually correspond to hypertrophied papillæ of the corium. In the deeper parts the cells are not so flattened, and the outlines of those next the rete mucosum can be distinctly seen. The pigmented cells of the rete mucosum are evident in most of the sections. The corium is not much thickened, but the papillæ are greatly hypertrophied, forming pointed projections, which give to the surface a serrated aspect. In places the papillæ are infiltrated with small cells, and into some dilated blood-vessels can be traced; when a hair follicle is cut, the inner root sheath is seen to be much developed, forming a thick laminated envelope about the hair. No sebaceous follicles are visible in the sections, but the sudoriparous glands are numerous in the subcutaneous tissue.

In the various chemical analyses of the concretions there has usually been found fatty matter in considerable quantity. Schlossberger has found crystals of cholesterine and hippuric acid; the ashes he found to contain chloride of sodium and potassium, and traces of gypsum and phosphates of iron, lime, and magnesia, he also found silica and oxide of iron.

In regard to the distribution of the disease over the surface, this case presents some features not commonly seen, thus it is present in the axillæ, in the popliteal space, and on the genitals, and the prevailing direction of the patches on the trunk and limbs is along the course of cutaneous nerves.

Hillier states that "when general, it avoids the palms of the hands, soles of the feet, the *axillæ*, the popliteal spaces, and the flexures of the arms." Neumann states that "the disease generally begins on the outer aspect of the extremities, and spares no part except the flexions of the joints, the *genitals*, and the face." In this case the affection began on the neck, spread down the back, and the limbs were invaded subsequently. He also states that "in rare cases it remains limited to small portions of the skin for years, and forms moderate depositions of dark-colored cells along the distribution of certain cutaneous nerves." Hebra states that "the malady is mostly diffused over the skin in such a manner that, with the exception of the bends of the joints, of the genitals, of the palms of the hands and soles of the feet, and face, it affects the whole skin, and especially attacks the skin of the elbows and of the knees, and the extensor surface of the extremities." He mentions exceptions, however, where ichthyosis hystrix occurred on the palms and soles, and where slight

degrees of ichthyosis occurred on the face, resembling pityriasis. He states further, that "usually the skin on the places mentioned appears affected *in continuo*, and mostly over patches at least as large as the palm of the hand. In *a few isolated cases*, however, the ichthyosis, and especially its higher grade—*hystrix*—occurs in the form of warty eminences arranged in rows, between which can be seen smaller or larger normal portions of skin. These elevations of the skin, arranged in the form of lines, have, as a rule, the same direction as the peripheral spinal nerves, which run beneath them." Duhring says, "the disease usually involves the whole surface more or less generally, although it always manifests itself more markedly in certain regions, these are the lower extremities from the hips down to the ankles, and the arms and forearms. The knees and elbows are in almost all cases the seat of considerable wrinkling, thickness, roughness, and scaliness; on the other hand, the flexions of the knees and elbows as well as the axillæ and groin, seldom show the disease at all." Tilbury Fox states, "the parts usually affected are the knees, elbows, and those about the ankles, wrists, and axillæ." Thus Hebra and Neumann both consider the cases rare and isolated in which the disease follows the course of cutaneous nerves, and both authors state that it never occurs on the genitals. In this particular, therefore, this case seems to be unique. The well-developed patches in the axillæ and groin are also very unusual, Duhring stating that the disease seldom occurs at all in these regions. In this case the affection was not inherited, as a similar disease was not known to have occurred in any of the child's predecessors. It must therefore be classed with those less frequently observed cases which are considered to be congenital, where, although as in this case, the child is born with a surface free from blemish, or any character which would indicate a future ichthyosis, yet the morbid condition is present in the skin which predisposes to this abnormal state of the epidermis.

As the child, from the time I saw him, was laboring under the disease which caused his death, I had no opportunity of following out any course of treatment. Mostly all of the remedies which have proved of benefit in skin diseases generally have been prescribed in this affection, but have proved unavailing in effecting a permanent cure, and only in some cases have afforded transient amelioration to the patient. Local therapeutics only have been found of any service, and the most useful of these are warm water and vapor baths frequently repeated, and frictions, with glycerin and various oleaginous substances; alkaline and sulphur baths are also of benefit. Hebra mentions some cases where complete cures followed attacks of measles and variola. This child was never known to perspire until a week or two before he died, when the sweating at night was sometimes very profuse; this soon had the effect of softening and loosening the epidermal deposits, so that at his death they were almost entirely removed from the most exposed parts of the body.

## CLINICAL REPORTS.

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### I. *A Case of Scleroderma vel Morphœa, with Hemiatrophy Facialis, Alopecia Areata, and Canities.* By V. P. GIBNEY, M.D., New York.

CASE.—Mary Marshall, æt. 9 years, was admitted to the Hospital for the Ruptured and Crippled, July 19, 1878, for the relief of talipes valgo-equinus of the left foot, induced by the disease indicated at the head of this report.

The case was first presented at the out-door department, July 13, 1876, when I observed a marked atrophy of the left side of the face, a deep, cicatricial-like sulcus to the left of the symphysis of the inferior maxilla, a roughening and mottling of the integument in the inferior maxillary region of the same side, a peculiar band-like condition of the skin over coccyx, with a like appearance over gluteal region, extending down the posterior surface of the thigh, leg, and outer border of the foot. The course taken by the disease was exactly in the distribution of the sciatic nerve. The skin over outer hamstrings was glistening, but could be caught between one's thumb and forefinger and raised a little from the tendon beneath. The comparative measurements were taken at that time, and will be compared later with those of more recent date.

The patient did not appear again until the 19th of July last,—an interval of two years elapsing,—and at that time a more thorough examination was made. It was now learned, first, that her family history, both paternal and maternal, was remarkably good; that the child herself had enjoyed good health during the first three years of life; in fact, that, with the exception of a pertussis, two years ago, and a rubeola, one month ago, her general health has always been very good. The present affection has not produced any constitutional disturbance, and all that can be learned which would indicate any deviation from health is that, for several years, she has moaned during sleep, as if in great pain, but never waking to cry out. One day, when about three years of age, there was observed by the mother a dirty-brownish discoloration in the left inferior maxillary region. It was about an inch in diameter, and could not be removed by washing. From this point the process extended upwards and towards the angle of the mouth, gradually enlarging in two years, as well as her mother can recollect, to its present dimension. No scabbing or ulceration has occurred on the face,

and no change of color at any time, unless under excitement, when the usual vaso-motor changes are observed. Over the left gluteal region a similar process began about the same time, and has acted in about the same manner. It grew to the size of one's hand, and by many was thought to have been a scar from a burn, so close was the resemblance. Extension took place downwards, and the mother did not observe any difference in the size of the limb until a year had elapsed. There has been no ulceration in its track, but at points where the deepest depressions are to be seen there has been a kind of dry scabbing observed. There has been no pruritus. Last year, for the first time, and again, two months ago, about a dozen small pimples appeared on the site of the lesion, disappearing spontaneously. The progress of case has been steady and gradual, not marked by pain or tenderness.

It is now two or three years ago since the gait became affected. This lameness has increased, though to-day she exhibits much power and endurance in a walk of about three miles. No regular course of treatment has been employed. Her complexion is fair, hair brownish, and she is fairly nourished. As she stands, the left foot is everted, and rests on the inner border, and as she walks a marked degree of lameness is observed.

To the left of the posterior fontanelle is a large lock of gray hair, a localized *canities*, while the scalp from which this grows presents no induration or atrophy, and is freely movable on the underlying tissue. The mother says this gray hair came first with the other signs of disease, and has existed about an equal length of time.

Over the left fossa is an area of baldness, one by one and a half inches in size, giving undue prominence to the blood-vessels here by the thinness of the skin, which is smooth, transparent, and mobile. This, so the mother says, has lasted a long while, and is called, Dr. Bulkley informed me some months later, *alopecia areata*.

In the inferior maxillary region, left side, the skin presents a slightly indurated appearance, mottled irregularly, and is freely movable. This area is bounded above by a line from the angle of the jaw to the angle of the mouth. From this point the margin extends to within a line of the symphysis, thence to thyroid, thence irregularly to angle of the jaw again. It corresponds closely with the distribution of the infra-maxillary branch of the facial nerve. Within this area and immediately to the left of the symphysis the skin is depressed into a sulcus, and hugs the bone closely, so that no movement can be made. Three lines to the left of this is a similar groove-like cicatrix, extending up to the angle of the mouth, drawing this angle down perceptibly. The incisors are very prominent, and the upper jaw overlaps the lower to the extent of half an inch. The lower half of the face, left side, affected by the *hemiatrophy facialis*, is about one-third smaller than that of right side. There are no marks of disease on the upper limbs or on the thorax.

In the umbilical region, to the right of the median line, is an

obliquely-oval patch of altered skin, five inches by one and seven-eighths in size. The color is pale, and the appearance in general exactly like that of an old vaccination scar without mottling or scaliness.

The skin is here freely movable, and on grasping it between the thumb and fingers it feels thinner than normal skin, although in passing the finger over the abdomen one cannot make out the boundaries of this placque; in fact, no difference can be felt between this and the surrounding skin. This has been tested by several prominent dermatologists, and they fail to recognize a difference in sensation as they pass the hand from sound to unsound skin. The mother says this has existed three or four years, though she does not know when it first appeared, and has not recognized any change from its present appearance save a disposition at times to scale.

The left buttock is flattened, and the skin (even to the right side, one inch beyond the coccyx) has a dusky-red appearance, the veins are quite prominent, and here and there we find the same vaccination-like placques, resembling the one on the abdomen, while over the trochanter and the coccyx the mobility is diminished. This hardened and bound-down condition of skin extends along the posterior surface of the left thigh, through the popliteal space, along the posterior surface of the leg, embracing both malleoli, and shading off into sound integument about the middle of the outer border of the foot. The front of the limb presents nothing abnormal. The subcutaneous cellular tissue along this tract is atrophic, and the skin lies directly upon the muscles, though not closely adherent thereto. The outer hamstring is tense and stands out prominently, while between this and the vastus externus is a groove which does not disappear when the leg is flexed. The limb can be completely extended. The group of muscles on the outer aspect of the leg are quite tense, as well as the skin overlying, and the foot is drawn in perfect valgus with moderate equinus. If the attempt is made to force the foot into a normal position, a crackling sensation is imparted to the hand placed over the tissues on the outer side. Voluntary flexion and extension are easily performed, though inversion is impossible.

Heart and lungs examined with negative results.

*Comparative Measurements.*

		July 13, 1876.	Feb. 25, 1879.
Thigh, right side . . . . .		12 in.	14½ in.
" left side . . . . .		11 "	12 "
Calf, right . . . . .		8½ "	10 "
" left . . . . .		8 "	7¾ "
Ankle, over malleoli, right . . . . .		6 "	7 "
" " left . . . . .		5¾ "	7 "
Foot in length, right . . . . .		7¾ "	8 "
" " left . . . . .		7 "	7½ "

The limbs were of equal length at both dates.

The circumference of the knees, July 19, 1878, was, right, 10¼

inches; left,  $9\frac{1}{2}$  inches, and on Feb. 25, 1879, eight months later, right,  $10\frac{3}{4}$  inches; left, 10 inches. No difference at the two dates, comparatively.

It will be seen, then, that the right thigh, the one not affected, has increased  $2\frac{1}{4}$  inches in circumference within two years and eight months, while the left has increased only one inch during the same period. This makes  $2\frac{1}{4}$  inches difference between the two now against 1 inch two years and eight months ago. The calves gave then only  $\frac{1}{2}$  inch difference; now,  $2\frac{1}{4}$  inches. The right, sound one, has increased  $1\frac{1}{2}$  inch, while the left has lost  $\frac{1}{4}$  inch in circumference.

The ankle over the bony structure, in the period named, shows no appreciable atrophy. The right has gained in the period named 1 inch, while the left has gained  $1\frac{1}{4}$  inches.

The feet, as to length, show steady and equal growth, with  $\frac{3}{8}$  inch difference in length between them, and  $\frac{1}{2}$  inch now.

The knees in circumference eight months ago gave a difference of  $\frac{3}{4}$  of an inch, and give now the same: each has increased equally.

On Nov. 30, 1879, Dr. Bulkley brought Dr. Dühring, of Philadelphia, to the hospital, and both examined the case very critically. Dr. Dühring observed an hypertrophy of the venous capillaries on both sides of the body, though especially marked in the track of the lesion.

He regarded the patch on abdomen as typical of morphœa in process of subinvolution, and felt confident that at some previous time the patch was hard. The lesion along the thigh he did not regard as true scleroderma, but rather as a condition representing the border line between scleroderma and morphœa.

The case has been presented at a meeting of the New York Dermatological Society, and is now under discussion, which discussion will appear in the Transactions of the same.

135 E. 42d Street.

## II. Case of Morphœa. By P. A. MORROW, Physician to the Skin and Venereal Department, New York Dispensary.

Alice Dowling, age 35, native of Ireland, unmarried, presented herself at my class at New York Dispensary in July, 1878. She is a dark-complexioned, rather stout, robust-looking woman, and her general health has always been excellent. About twelve months previous she noticed a white patch, like a scar, on the anterior aspect of her right arm, just below the flexure of the elbow. It had occasioned no pain or inconvenience, and her attention was attracted to it by accident. Two or three months later she noticed a similar patch, but larger, on upper part of same arm, and still later, a change in the color of the skin over the right cheek.

Upon examination there is found on the outer anterior aspect of

forearm, just below the flexure of the elbow, a yellowish-white, oval-shaped patch of integument, distinctly circumscribed with a brownish margin. It is about one and one-quarter inches by three-quarters of an inch in size, not elevated above the surrounding skin, into which it seems to be artificially set. It has a hard, horny feel, and cannot be pinched up from the underlying tissues.

On the arm, three inches above this, is a similar patch about the size of a silver quarter.

The principal patch of the disease is situated over the region of the deltoid insertion. It is irregularly circular in shape, and measures one and one-half inches in a line corresponding to the long axis of limb, by two inches transversely. The skin has a white, waxy appearance, exactly comparable to the surface of leaf lard, and is marked by minute transverse corrugations, which give it a glazed and shiny aspect. It is perceptibly elevated, and the integument feels thickened, hard, and unyielding. On its axillary side the patch has a faint pinkish margin. Its upper and outer borders are marked by a broad margin of a mottled brownish pigmentation, interspersed with numerous milky-white spots. The lower border fades gradually into the sound skin. When the surface is scratched it yields fine laminated scales, which, when separated, have a micaceous gleam.

Scattered around this central patch, and extending two or three inches beyond its periphery, especially upwards and outwards, can be seen numerous small leucodermic spots, which are evidently outposts of the advancing disease. These white spots are each surrounded by a pigmented ring, the brownish tint of which throws them in strong relief.

The area of this affected surface, taking in that invaded by the white spots, measures four or five inches in diameter. These spots can be traced down the front of the arm to the elbow, not continuously, but sprinkled here and there with areas of healthy skin intervening. They are especially numerous around an old vaccination cicatrix, the upper part of which seems to be undergoing a modification due to the disease.

Upon the right side of the face there is a circumscribed surface which appears to be undergoing the first changes of the disease, and which might be mistaken for a vitiligo. This surface is elliptical in shape; its transverse diameter, corresponding to a line drawn from the malar prominence to the angle of the jaw, measures three and one-quarter inches; its conjugate diameter, extending from the angle of the mouth to middle of the cheek, measures one and three-quarter inches. This patch is neatly defined by a pigmented margin of yellowish brown. The skin is thin, white, and delicate, presenting a faint roseate hue, in marked contrast to the freckled, brownish coloration of the surrounding skin. The hairs of the affected portion appear to have been bleached by the morbid process.

No other portions of the body are as yet involved. There is an intense itching around the patches on the arm, which provokes

almost constant scratching. With this exception, there is an entire absence of all subjective symptoms.

The temperature of the principal patch, carefully tested with a Stewart's clinical thermometer, was found to be raised .8 of a degree above that of the adjacent normal skin, as well as that of the corresponding portion of the left arm.

The changes which the disease has undergone during the four months the patient has been under my observation have not been material. The patch on the forearm has grown smaller, it has lost its hard and horny feel at the periphery, and the ivory color has deepened into a dirty white, like chamois-skin.

The dead white of the upper patch is gradually merging into a yellow or yellowish-white color.

## EXTRACTS AND TRANSLATIONS.

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### CASE OF HYPERTRICHOSIS (HOMO HIRSUTUS).

TRANSLATED FROM THE HOSPITALS-TIDENDE, SEPTEMBER 25, 1878,  
VOL. V., NO. 39, P. 609. BY H. J. GARRIGUES, M.D., OF BROOK-  
LYN, NEW YORK.

**D**R. C. KREBS, of Copenhagen (Denmark), has described a case of a boy, Karl Marinus S., 15 months old, born in Jutland, who was sent to the clinic of Dr. S. Englested, in the City Hospital of Copenhagen, in order to be treated for a rare abnormality. The whole body, except hands and feet, was covered with a dense growth of soft hairs of very different lengths on the different parts of the body. They were particularly well-developed on the humeri and on the back, where they pointed in a direction from the sides toward the median line, and formed a ridge corresponding with the spine. The hairs were so long that they were easily seized with the fingers; fully three centimetres and a half (one inch and a half) in length. The whole face was likewise covered with a close crop of hairs, with the exception of the eyelids, the nostrils, and the external meatus of the ears. The hair of the head was long, close, silky, and of a yellowish color. The eyebrows were bushy and coalescent. On the cheeks were found well-developed whiskers, about five centimetres (two inches) in length. On the upper lips the hairs were likewise comparatively long. Their color was everywhere light yellow.

This uncommon growth of hair was not present when the child was born, but was developed three months later, simultaneously with an outbreak of scrofula (impetigo of the head, adenitis of the neck, and inflammation of the eyes).

The other members of the family had also a rather profuse growth of hair, especially the father, who had uncommonly dense hair on the head, shaggy beard and eyebrows, but none of them had in childhood presented an appearance similar to that of this boy.

The child was well nourished, strongly built, and exceedingly lively and intelligent. It had the two first incisors in the lower jaw; no trace of formation of other teeth. During its sojourn in the hospital hairs began to cover the hands and first phalanges. By Vienna paste, applied for one minute, the hairs were destroyed on the brow and between the eyebrows, when the patient was taken home.

This little fellow had much analogy with the two Russian "dog-

men," Adrian and Feodor, described by Virchow (*Berliner Klinische Wochenschrift*, vol. x., No. 29), by Charles C. Tomes and Oakley Coles, with portraits (*British Medical Journal*, 1874, 1), and by Hebra likewise, with portraits, in his *Atlas of Skin Diseases*.



As far back as 1829, Mr. Crawford had found a family in the kingdom of Ava, in Asia, which in three generations presented the same superabundance of hair and scarcity of teeth (described by Beigel in *Virchow's Archiv*, vol. xxxiv.).

#### OBSERVATIONS ON EXTRA-GENITAL CHANCRES.

BY ALB. HULOT, PARIS. TRANSLATED AND ABSTRACTED BY W. T. ALEXANDER, M.D., OF NEW YORK.

**I**N the *Annales de Dermatologie et de Syphiligraphie*, tome x., No. 1, are published a number of observations of extra-genital chancres, a condensed summary of which is given below. Most of the cases were observed at the Hôpital Saint Louis in the service of Dr.

Fournier, a few were taken from the private practice of Dr. Fournier, and one from that of Dr. Lailler.

*CASE I.—INFECTING CHANCRE OF THE LEFT TONSIL.*

Josephine B., aged 27 years, had always enjoyed good health. She has been married four years to a healthy husband. Three months before entering the hospital, she began to feel a slight pain in her throat, upon the left side, persistent, but not increased on swallowing; a week later a lump appeared under the angle of the jaw, on the same side. Examination showed that the left tonsil was red, tumefied, and hard to the touch. On the left anterior pillar of the fauces was a superficial ulceration with red base, in process of repair. The submaxillary gland on the left side, hard, indolent, and movable. Diagnosis, infecting chancre of the tonsil. Investigation showed that the patient was in the habit of kissing a child, who had at the left labial commissure a hard chancre, which it had contracted from its mother. A few weeks later the diagnosis was confirmed by the appearance of a papular syphilide upon the vulva.

*CASE II.—INFECTING CHANCRE OF THE RIGHT TONSIL.*

Q., aged 23 years, had a sore throat two months ago, with pain on swallowing. At present the upper part of the right tonsil is the seat of an ulceration, with irregular, worm-eaten edges, about one inch in diameter. Its surface is covered with whitish shreds, between which can be seen the reddish inflamed base of the ulcer. Surrounding tissues somewhat indurated. Behind the right angle of the jaw was an enlarged and indurated gland. Diagnosis, hard chancre of the tonsil. A general roseola appeared a few days later.

*CASE III.—INFECTING CHANCRE OF THE RIGHT TONSIL.*

X., aged 30 years, married, sought the advice of Dr. Fournier for her child, who was suffering from a chancre on the neck and opaline patches of the mouth and tonsils. The patient was advised to abstain from kissing the child, but whether she disregarded the advice, or already had the germs of the disease in her system, about one month later she began to have pain in the throat on the right side. A few weeks after this she again presented herself to Dr. Fournier, who recognized a characteristic infecting chancre on the right tonsil. Two days later a papular syphilide made its appearance, and soon became general.

*CASE IV.—INDURATED CHANCRE OF THE SUPERIOR LABIAL FURROW.*

H., aged 32 years, had seven years ago a phagedenic and gangrenous sore on the penis, which healed, leaving a large white depressed cicatrix in the balano-præputial fold. Six weeks before he entered the hospital he was kissed upon the mouth by an impure woman, with whom he had no other intercourse. One month later he noticed an ulceration above the upper central incisor teeth, which spread rapidly and became harder, and was followed shortly by a papular eruption over the whole body and a number of small ulcers

on the scrotum. Examination revealed an ulceration on the gum as large as an almond, oblong-oval in shape, laying bare the roots of the incisors and a portion of the alveolar process. Induration of the base readily appreciable by touch. Submaxillary glands enlarged and hard on both sides. A few days later auto-inoculations were practised with the discharge from the ulcer of the gum and from the scrotum, with negative results.

*CASE V.—INDURATED CHANCRE OF THE RIGHT UPPER EYELID.*

G., aged 30 years, has for the past eight months had the care of an infant the subject of congenital syphilis. Three weeks ago the patient noticed upon the right upper eyelid a painful tumefaction, and had at the same time a feeling of great lassitude, and nocturnal pains in the head and limbs. Examination revealed a sharply-defined swelling on the right upper eyelid, with a cartilaginous induration of the most pronounced character. On evertting the lid, its inner surface was seen to be edematous, infiltrated, and ulcerated at the inner angle. Characteristic painful engorgement of the præ-auricular gland: a papular eruption scattered over the body. Four months later all the lesions, except the last, had yielded to antisyphilitic treatment.

*CASE VI.—INFECTING CHANCRE OF THE NOSE.*

G., aged 40 years, has had for the past six weeks, upon the end of his nose, a dark-yellowish, cap-like, rounded crust, which is re-formed as often as removed. He admits having exposed himself to contagion upon the part one month before the appearance of the crust. At the time when he first noticed it he felt very unwell, and has since suffered from nocturnal headaches. On examination the skin around the crust was of a dusky-red color to the extent of four or five mm., and between the two was a narrow yellowish-white zone, corresponding to the induration of the base of the erosion under the crust. Enlarged glands behind the angles of the jaws. On both sides of the neck slight secondary adenopathy, corresponding to mucous patches of the tonsils and soft palate. A general erythematous and papular eruption on the body. All the symptoms yielded readily to specific treatment.

*CASE VII.—INFECTING CHANCRE OF THE ALA OF THE NOSE.*

M., aged 45 years, noticed two months ago a slight erosion behind the right ala nasi, which she got into the habit of picking with her fingers. It was for a while absolutely indolent. Two weeks ago a papular eruption appeared all over her body. When examined the erosion was about half an inch in diameter, covered with a thin yellow crust, with sharply-cut, slightly undermined borders, and surrounded by an inflammatory halo. Marked induration of the base. Corresponding submaxillary adenopathy was also present. Some enlarged glands were present in the neck and groins, without lesions around the anus or vulva.

*CASE VIII.—INFECTING PHAGEDENIC CHANCRE OF THE RIGHT ALA OF THE NOSE, WITH A SIMPLE INDURATED CHANCRE OF THE LEFT LABIAL COMMISSURE.*

Louis, aged 46 years, noticed six weeks before a papule upon the right ala nasi. He scratched it frequently, and it finally became ulcerated and spread rapidly. Examination revealed an ulcerated surface, separated into two parts by a solution of continuity of the nasal wall, on both sides of which were bleeding surfaces, with a narrow inflammatory halo. Cartilaginous induration of the base was easily recognized. There was also a large ulceration covered with a scab at the left labial commissure, and under the crust a hemorrhagic surface upon an indurated base, presenting all the marks of an infecting chancre. There were adenopathies corresponding to the two lesions, which might have seemed crossed, for on the right side the submaxillary glands were small, hard, indolent, and mobile, while the præ-auricular gland was affected on the left side, and here the inflammation had been sufficiently acute to cause the gland to attain the volume of a nut, and present an indistinct fluctuation. This was probably due to the phagedenic character of the nasal lesion. Cervical and inguinal adenopathy was also present, as well as a scattered papular syphilide on the body. The mode of contagion could not be ascertained.

*CASE IX.—TWO INDURATED CHANCRÉS SYMMETRICALLY LOCATED ON THE CHEEKS.*

D., aged 20 years, noticed, two months before entering the hospital, a flat papule on either cheek, 3 cm. from the labial commissures. On examination they were but slightly elevated, indolent, with reddish base, crusted over, and decidedly indurated. A bubo at each angle of the jaw, sub-hyoidean glands enlarged, and hard mucous patches on the tonsils and internal surface of the cheeks, and an erythematous syphilide over the whole body. The mode of inoculation could not be ascertained, and it is only conjectured that the patient scratched his face after having had his hand in an infected place.

*CASE X.—INFECTING CHANCRE OF THE CHIN.*

H., 59 years of age, has for the past six months been bringing up a child on a bottle, which she was in the habit of putting to her own mouth before giving it to the child. When six weeks old the child's body became completely covered with spots, and it died soon afterwards. Three weeks later the patient noticed just above the chin a papule, crusted over, with indurated base, and surrounded by an inflammatory halo. There was an enlarged gland under the right angle of the jaw. There soon appeared a general papular eruption. The nursing-bottle was evidently the medium of contagion in this case between the buccal mucous membrane of the child and the face of the patient.

*CASE XI.—INFECTING CHANCRE OF THE NECK.*

Dr. Fournier was consulted by a young man for an obstinate "boil" on the neck, upon a spot which some time before had been

bitten by a prostitute in an amorous transport. The lesion presented the appearance of a typical chancre, and was much indurated. A short distance below was a characteristic bubo. A few weeks later violent secondary symptoms made their appearance, which yielded to specific treatment.

*CASE XII.—INFECTING CHANCRE OF THE NECK.*

A young woman had on the right side of the neck, on a level with the fifth cervical vertebra, an oval erosion as large as a thumbnail, with slightly elevated edges, and a narrow inflammatory areola, base smooth and glazed, covered with a grayish-red membrane, with marked parchment induration. There was an enlarged hard gland in the neighborhood. No history of infection could be obtained from the patient. In a few weeks a characteristic roseola appeared, and mucous patches on the lips and vulva, which speedily yielded to treatment.

*CASE XIII.—INFECTING CHANCRE OF THE NECK.*

A child, 22 months old (of Case III.), had on the left side of the neck, below and behind the mastoid process, a macule of a brownish-red color, the size of a bean. This had been the seat of an ulcer which took two months to heal. Examination showed no induration of the base of the papule, but three enlarged glands below the mastoid process. It was concluded that the ulcer was an infecting chancre with slight temporary induration, an opinion which was confirmed by the subsequent appearance of a roseola. Investigation established the fact that the child's nurse had had a sore throat and an eruption on the skin a short while before, and she admitted having kissed the child upon the spot which afterwards became ulcerated.

*CASE XIV.—CHANCRE OF THE CHEEK.*

M., aged 21 years, has for the past three months had brownish spots all over his body. He says that they cause intense itching, particularly in the back. On the shoulders are a number of papules which show the effects of scratching, which is explained by the fact that he has an intense phthiriasis corporis. One papule which made its appearance at about the same time as the parasitic disease three months ago has gone on spreading, while the others have gradually disappeared. Situated on the left cheek in front of the ear, just at the base of the tragus, this papule has become transformed into an ulcer the size of an almond, and presents, when the crust over it is removed, the appearance of a hard chancre. There were enlarged indurated glands under the mastoid process, behind the neck, and in the groins. For five weeks the patient has had a papulo-eruptive syphilide upon the scrotum, and mucous patches upon the tonsils. It was impossible to obtain a satisfactory account of the source of contagion.

*CASE XV.—INFECTING PHAGEDENIC CHANCRÉS OF THE BREASTS.*

N., aged 28 years, had always enjoyed good health until she took a child to nurse four months before she entered the hospital. Three

weeks before, three papules appeared around the right nipple and two at a corresponding point on the left side. When she entered the hospital she had double axillary adenopathy, and the hard chancres had taken on phagedenic action, a rare complication which was doubtless due to the profoundly anaemic condition of the patient. Above both nipples were large, deep, crescentic ulcerations of gangrenous aspect, surrounded by inflamed and indurated tissues. Under the use of the protiodiode of mercury internally, and iodoform locally, the ulcers rapidly healed. Six weeks later appeared a roseola.

*CASE XVI.—CHANCRE OF THE ABDOMEN.*

H., aged 25 years, presented himself with a general papular syphilide undergoing involution. On the dorsum penis is the indurated cicatrix of a former ulcer. Enlarged glands in both groins. Just below the umbilicus was a small brownish crust surrounded by an inflammatory halo. Patient says that he frequently has similar spots in the same locality. He has a well-marked roseola all over the body. Soon afterwards the spot upon the abdomen became more painful and larger, and after removal of the crust an ulceration was revealed which presented the aspect of a typical hard chancre. It was then ascertained that the abdominal lesion had appeared before the roseola and the sore on the penis.

*CASE XVII.—INDURATED CHANCRE OF THE RIGHT INDEX FINGER.*

J., aged 23 years. Five months previously, while the patient had a scratch upon his finger, he exposed himself, with an erotic purpose, and contracted a contagious disease upon the part. Six weeks later, he noticed that the scratch was ulcerating and spreading. He put himself under treatment, and at present the chancre is entirely healed. The induration around the cicatrix and the purple color of the skin have persisted, as well as the primitive axillary adenopathy, but the latter is less marked than that in the inguinal and cervical regions, corresponding to ulcerative syphilitic lesions of the glans and prepuce, the tonsils and tongue. The patient has also double consecutive epididymitis.

*CASE XVIII.—INFECTING CHANCRE OF THE LEFT MIDDLE FINGER.*

J., aged 28 years, scratched himself, six weeks before entering the hospital, with a nail, on the middle finger of the left hand. The scratch was irritated and inflamed at the time when he introduced the hand into a suspicious locality. From this time the inflammation became stationary, the finger remaining slightly swollen and painful. Suddenly, about a month later, the skin of the finger became of a violet-red color, and the wound again ulcerated. He soon experienced a sensation of great fatigue, nocturnal pains in the head and left axilla. On examination, the patient was found to have a chancre on the dorsum of the left middle finger, occupying the space between the root of the nail and the end of the phalanx, and adenopathy of the left epitrochlear

and axillary glands. Under specific treatment the nail fell off, and the sore took on a healthier action. Three months after the infection, a syphilitic eruption appeared on the body.

*CASE XIX.—INDURATED CHANCRE OF THE REGION OF THE LEFT TROCHANTER.*

M., aged 19 years, was exposed to direct contagion one month before the appearance of the following lesion: Over the left trochanter major is a large cicatrix, in the centre white, in the periphery of a dusky-red color, with induration of the base. Glands enlarged in outer third of the left groin. On the right side a lesser degree of induration. He has had spots of a papular syphilitic eruption on his body for three months, and his hair has been coming out for two months. He had been in the habit of sleeping with a young man, the subject of an ulcerative syphilitic affection of the glans penis, complicated with an enormous paraphimosis, who frequently touched his companion in turning over in bed, and the latter frequently scratched the part touched. This fact affords a ready explanation of the mode of infection.

In the same journal, page 78, are reported the following two cases of buccal chancre, by Dr. Spillmann (copied from *La Revue Médical de l'Est*, 15th Nov., 1878).

*CASE XX.—CHANCRE OF THE RIGHT TONSIL.*

A lady of 59 years, of irreproachable morals, had a sore throat, with enlargement of the glands on the right side behind the angle of the jaw. On the right tonsil was found a superficial, circular, slightly-excavated erosion, covered with a grayish pseudo-membrane. The surrounding mucous membrane was œdematosus and infiltrated. Glands in parotid region were engorged and painful. The character of the lesion was not recognized until the appearance a few days later of a roseola. It was then ascertained that the patient had been bringing up on the bottle a syphilitic child, and that she was accustomed to put the bottle to her mouth before giving it to the child, who was found to have mucous patches on the mouth and genitals.

*CASE XXI.—CHANCRE OF THE LOWER LIP.*

The second case was that of a boy, aged 13 years, who had on his lower lip a small, red, indurated patch, with enlargement of the submaxillary glands. His genitals were healthy, and his parents had never had syphilis. It was found that the patient worked with a carpenter, the subject of mucous patches in the mouth, and was in the habit of taking nails out of the same bag with him, and that they were both accustomed to carry a number of nails in the mouth, and to throw back into the bag such as they did not use. The etiology of the infection in the case of the boy was thus explained. He subsequently developed secondary symptoms.

## DIGEST OF LITERATURE.

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### I.

#### DISEASES OF THE SKIN.

##### GENERAL TOPICS AND THERAPEUTICS.

EDWARD B. BRONSON, M.D.

**Boracic acid in skin diseases.**—DR. I. NEUMANN has found this remedy quite efficacious in pityriasis versicolor, herpes tonsurans, pruritus cutaneus, urticaria, and eczema. He used the alcoholic solution previously employed by Nyström and Gahn, consisting of boracic acid, one part; alcohol, thirty parts; sufficient glycerine to dissolve the acid, and a few drops of clove oil. The solution was applied with a brush. He also employed an ointment with paraffin, wax, and oil, and another to which glycerine was added. The salve was spread on linen and found especially useful in eczema.—*Pest. Méd.-Chir. Presse*, xiii., 52, 1877; *Schmidt's Jahrb.*, 1878, No. II.

**Dermatophony.**—PROF. HUETER, of Greifswald, has made an interesting application of Edison's microphone, for the purpose of detecting sounds in the human body which are inaudible by ordinary means. He is thus able to hear sounds produced by muscular contraction, by tendinous extension, the vibration of long bones when percussed, and by the rush of blood through the capillaries of the skin. To these various sounds have been applied the terms myophony, tendophony, osteophony, and dermatophony, of which the last named is perhaps the most interesting. He had observed that, without the microphone, when the tip of one of his fingers was pressed firmly into the external auditory meatus a certain humming noise was heard, which was not present when a simple plug of wood or cork was similarly used. He then found that the same murmur was detected when the finger-tip was placed upon a wooden disc attached to the microphone. When the circulation of the blood was stopped by an Esmarch bandage the sound was absent. A special instrument was devised by Hueter, which could be conveniently applied to the skin in various parts of the body. This instrument, called the dermatophone, consists of a flexible stethoscope with a thin caoutchouc membrane stretched over the end to be applied to the skin, and a perforated horn plug to fit the ear, closing the meatus as closely as possible. With this contrivance he ascertained that the capillary murmur was most distinct wherever the

circulation was most vigorous, as on the cheeks and at the finger-tips. In acute inflammation of the skin with marked inflammatory hyperæmia, the murmur was louder and deeper in tone than in the normal state. Where venous stasis existed, as in the neighborhood of ulcers of the leg, it was weak, and over extensive scars it was entirely absent.—*Centralbl. Med. Wiss.*, Nos. 51, 52, 1878. Editorial in *Med. Times and Gaz.*, Feb. 15, 1879.

**Kaposi on chrysophanic acid or chrysarobin and pyrogallic acid.**—KAPOSI refers to investigations of the chemist C. Liebermann, of Berlin, showing that the acid obtained in such large quantities from Goa powder is not, as supposed by Squire, chrysophanic acid, but a neutral chemical substance differing from the former in certain essential particulars. This neutral substance is termed by Liebermann chrysarobin, and stands in such close chemical relation to chrysophanic acid that it can be readily changed into the latter by additions of potash and exposure to the air, a part of its hydrogen being replaced by oxygen. K. is inclined to doubt whether pure chrysophanic acid as obtained from rhubarb would have the therapeutic effect of chrysarobin. He employed the same preparations as recommended by Squire, namely, a mixture in ointment or vaseline, in the proportions 5—10 to 40. He also employed a salve consisting of Goa powder, 20; vaseline, 80; acetic acid, 10. The acetic acid was added for the purpose of extracting the chrysarobin. He found that less irritation of the skin was produced by this preparation than by the chrysarobin ointment. His testimony to the virtues of the remedy in psoriasis fully confirms the experience of Squire and others. In respect to speed of recovery, he found that this remedy far excelled all others. In three to four days the patches showed marked improvement, and often in six to eight days had completely disappeared. Where the patches were thick and horny, as upon the elbows and knees, he found it better to first employ the curette and then apply the chrysarobin salve.

In regard to the inflammation of the skin caused by the drug, K. distinguishes three varieties. In the first a simple diffuse redness and swelling surrounds the whitened patch like a halo, which disappears soon after the applications have ceased. In the second form the inflammation extends over a large surface, and is accompanied with febrile symptoms. There is considerable pain, burning, and itching of the affected parts, together with more or less affection of the lymphatics. In the third variety, beside the erythematous eruption, papules occur, scattered over the surface or aggregated together, which occasionally become vesicular or pustular. These correspond to the mouths of follicles. They spread over considerable portions of the skin, and often boils are produced. These attacks, unfortunately, often predispose to fresh outbreaks of psoriasis. Hence it is cautioned to be circumspect in the use of the remedy, and that, where it is possible, the physician make the application himself.

The action of pyrogallic acid in skin diseases has been specially

investigated by Dr. Jarrish, assistant at Hebra's clinic in Vienna. He was led to its use through the theory that the near chemical relation of pyrogallic and chrysophanic acids implied analogous therapeutic effects. According to J., pyrogallic acid is a binoxyphenol, with the rational formula  $C_6H_5(OH)_2$ . It is readily soluble in water, spirit, and ether. A twenty per cent. ointment of the acid will often produce a deep caustic effect. Kaposi used a ten per cent. salve with vaseline. It stains the skin a dirty brown color and gives it a leathery appearance. The epidermis exfoliates in one and a half to three weeks. It can be applied without pain to excoriated spots, and causes no inflammation of the surrounding skin. Its action in psoriasis is less rapid than that of chrysarobin, but still very efficient. The advantage of not causing inflammation renders it very serviceable in certain cases that will not tolerate the chrysarobin. It can be used with impunity upon the face, and is better adapted to application to the scalp than chrysarobin, the brown staining of the hair being less objectionable than the variegated discolorations produced by the latter. K. also used the strong acid in some cases as a caustic, with marked success. It is claimed that the action is quite painless. In cases of epithelioma of the face it was found to remove the diseased portions of tissue as thoroughly as an arsenical paste, and did not affect the sound parts.—*Wein. Med. Wochensch.*, 44, 45, 1878.

**Sulphate of copper in skin diseases.**—DR. BARDUZZI, of Pisa, in a paper read before the Eighth Italian Medical Congress at Turin, reported eight cases of skin disease treated with marked success by the internal use of sulphate of copper. Three of them were cases of pelagra, the others cases of eczema or herpes, complicated with various cachectic or diathetic conditions. The drug is recommended in such skin diseases as are produced by a defective or atonic state of nutrition, or by poorness of the blood. It is claimed that by it trophic changes are effected rapidly and without toxic effect. It is best administered in pill, in doses gradually increased from one or two to seven centigrammes a day.—*Indipendente*, Torino, 1878, xxix., 529-534.

**Unguentum vaselini plumbicum.**—The unguentum diachyli of Hebra, as is well known, is a preparation not only somewhat difficult to prepare properly, but very liable to become rancid. Even when of good quality the ointment will sometimes cause so much irritation as to preclude its use. These disadvantages are very largely overcome in the ointment made with vaseline instead of olive oil. It is prepared by simply melting and stirring together equal parts of emplastrum diachyli and vaseline. Dr. Kaposi speaks highly of this preparation, though he is evidently unaware that it had already been in use in this city for at least two years. It was first suggested by Dr. Piffard, who presented a specimen of unguentum vaselini plumbicum before the N. Y. Dermatological Society,

at the meeting held April 11, 1876, and reported in the July (1876) number of the Archives of Dermatology.—*Wiener Med. Wochensch.*, No. 17, 1878.

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## DISEASES OF THE GLANDS.

ROBERT CAMPBELL, M.D.

**Treatment of acne.**—BROWN makes use of liquid carbolic acid in pustular and tubercular acne, applying it to the centre of each pustule by means of a pointed glass rod or blunt piece of wood. Care must be taken not to allow the acid to touch the sound skin.—*British Medical Journal*, July 27, 1878, p. 162.

**Treatment of acne by the internal administration of sulphide of calcium.**—CANE gives in detail the histories of two cases of obstinate acne, chiefly of the punctate form, in which a cure was effected by means of sulphide of calcium, commencing with one-tenth of a grain, combined with four grains of powdered loaf sugar, in form of powder, four times a day, and gradually increasing until the patients took one grain six times in twenty-four hours. Cane says that he has treated fourteen other cases in the same way ; in eleven the cure was perfect, while in the remaining three there was considerable benefit derived from the administration of the drug. The patient should be cautioned not to wear metallic ornaments, as the sulphuretted hydrogen given off from the lungs and skin forms with the metals a sulphide, which tarnishes any ornaments worn about the person. The powder also deteriorates on exposure to the air, so that it is necessary that it should be kept in a bottle with a tightly-fitting stopper, or box with an air-tight lid.—*Lancet*, Aug. 17, 1878, p. 216.

**Treatment of acne.**—CUMMING reports a case of acne indurata that had existed fourteen years, and which was cured in two months and a half. The treatment employed was an ointment containing two drachms of each of the following : Lac sulphur, glycerine, carbonate of potassa, and benzoated ointment, to be applied each night to an area about the size of a five-cent piece. Internally, twenty drops of the tinct. ferri chlor., three times a day, was given. Four years after all treatment had been discontinued the patient was seen, and her face was smooth and white.—*Lancet*, Aug. 10, 1878, p. 182.

**Treatment of acne rosacea.**—HEBRA treats the telangiectasic condition of acne rosacea by means of punctures, which causes an obliteration of the dilated blood-vessels. He makes use of a needle with a lance-shaped, two-edged blade, about one-twelfth of an inch long, and provided with a shoulder to keep it from penetrating too deeply. The punctures are made as close together as possible, the needle being driven as far as the projecting shoulder. It is desirable that all the diseased tissue should be operated on at one sitting. Hemorrhage is easily controlled by compression, and if there be any suppuration, diachylon ointment or simple cerate should be

applied to the surface. Several operations may be necessary to effect a cure.

Where there is, in addition, considerable thickening of the skin and numerous pustules, the surface is scraped with the sharp curette; repeated scrapings are often requisite before the eruption disappears.

In the hypertrophic forms of the disease the protuberances are cut off or trimmed down.—*Wiener Med. Wochenschrift*, Jan. 5, 1878. (*New York Medical Record*, Aug. 3, 1878, p. 89.)

**Treatment of acne rosacea.**—HENDRY has obtained good results from the use of bisulphite of soda, fifteen to twenty grains, three times a day, or the hyposulphite in larger doses in the treatment of acne rosacea. These remedies should be prefaced by a dose of calomel and jalap. When the eruption begins to disappear he gives nux vomica three times a day before meals.—*Lancet*, July 13, 1878, p. 71.

**The topical treatment of acne rosacea.**—The following local treatment is recommended for acne rosacea in IL MORGAGNI: By means of a small hair pencil, the pustules are to be touched with a dilute solution of hydrochloric acid, one part of the acid with from three to ten parts of alcohol, then wiping off the solution by means of a piece of cotton, and applying a chlorate of potassa solution, in the proportion of four grammes of the salt to one hundred grammes of water. The object of the potassa solution is to avoid any inflammation that might result from the use of the hydrochloric acid. The application should be made every two or three days.—*Il Morgagni; La France Médicale*, May 8, 1878, p. 291.

**Molluscum contagiosum.**—DR. FANCOURT BARNES reports five cases of molluscum contagiosum occurring in one family. The disease first made its appearance on the hands and face of a girl aged seven; she was in the habit of nursing and playing with her brother, an infant eight months old, who caught it, and from thence it was conveyed to the mother's breast. The father next became affected, as was shown by two tubercles under his left eye. Lastly, another child caught the disease from the baby. In order to ascertain the nature of the tubercles, their contents were expressed and found to contain sebaceous matter. These cases are narrated in order to show the contagious nature of this form of molluscum.—*British Medical Journal*, March 9, 1878, p. 335.

**Molluscum contagiosum.**—DRS. TILBURY FOX and THOMAS C. FOX, in a communication to the Pathological Society of London upon the minute anatomy of molluscum contagiosum, say that the disease is of glandular origin. They believe that the lesion begins with a hypertrophic growth of the sebaceous gland in which the lobules become multiplied and their cells greatly increased, and transitional stages can be traced between that condition and the fully-developed molluscum tumors. The changes that go on in the cells of the tumors consist in the rapid endogenous formation of

"schleim-cells," preceded by great activity of the nuclei. This is seen especially in the outermost of the cells, and free vacuolation takes place in all of them as they advance towards the centre of the acini and to the excretory duct. The so-called mollusc bodies are nothing more than these completely vacuolated cells, which have undergone some peculiar transformation of the normal sebum. In the expressed contents of molluscum are observed cuticular cells like those of comedo, and mollusc bodies, viz., altered gland-cells. The latter are seen now and then to be imbedded in the cuticular cells, which often exhibit moulds from which the mollusc bodies have dropped. Fox has never found fungus elements in any fresh tumor, but has seen plenty of fatty granules, altered blood-cells, and oil globules, that might easily be mistaken for fungi, whilst the irregular edges of the cuticular cells sometimes present an appearance like mycelium. No opinion was expressed as to the contagiousness of the disease. Path. Soc. of London.—*Lancet*, Oct. 19, 1878, p. 547.

**Contagiousness of molluscum contagiosum.**—LIVEING, in a letter to the London *Lancet*, reports nine cases of this disease occurring at the same time in a school. The disease first appeared during November, 1877, and in only one child. Soon after Christmas, and before the first child was well, the molluscum appeared on several other children, and later on others were affected; in all, nine suffered more or less severely. In most cases the eruption was limited to the face and neck, and, after lasting for some months, disappeared without treatment. He believes that the evidence is strongly in favor of the disease being contagious. Correspondence.—*Lancet*, Oct. 5, 1878, p. 494.

**Molluscum sebaceum.**—SMITH says that out of a total of over 5300 cases observed and registered in the past nine years at the Adelaide Hospital, Dublin, 25 of them were recorded as molluscum sebaceum, or about one in 200. He believes that the disease is contagious, and gives cases to prove this. In regard to position, 17 out of 24 cases occurred on the face or neck, and 11 of the patients were males, while 14 were females. He lays great stress on the importance of making a correct diagnosis, as some cases of molluscum contagiosum occurring on the vulva have been mistaken for indurated chancre, and the patients treated for syphilis, mercury being given. Smith advises the removal of the hypertrophied gland, by squeezing out its contents, either with the nails or a pair of dressing forceps, and then cauterizing the interior of the cavity with nitrate of silver. When on the face, and about the size of lichen papules, a small drop of acid nitrate of mercury pressed firmly into the central depression will effect a cure. When the tumor is pedunculated it is best to snip it off and cauterize the base.—*Dublin Journ. of Med. Science*, Nov. 1878, p. 371.

**Inoculability of molluscum contagiosum.**—In proof of the inoculability of molluscum contagiosum, VIDAL gives two cases, in

one of which the characteristic tumor appeared three months, and in the other six months, after inoculation. Société de Biol.—*Le Progrès Méd.*, June 22, 1878, p. 478.

**Use of soft-soap in glandular affections.**—DR. KAPPESSEY gives four cases of chronic glandular swelling, occurring in strumous patients, in which the inunction of soft-soap is said to have effected a cure. About half an ounce of soft-soap was dissolved in a little tepid water, and this was rubbed into the back and thighs, from the neck to the knees, with a piece of soft flannel, twice a week, at bedtime; it was allowed to remain on about ten minutes and then washed off. The author wished to direct attention to its use in chronic inflammation and ulceration of the joints, believing that the employment of the above treatment will prove beneficial.—*Berliner Klinische Wochenschrift*, Feb. 11, 1878; *Monthly Abstract of Medical Science*, May, 1878, p. 211.

**Treatment of chronic adenitis.**—The following is recommended for chronic adenitis: R.—Emplast. hydrarg., 3ss; pulv. opii, pulv. camph. aa gr. xiii. M.—*Dictionnaire de Méd. et de Thérap.* (*Phil. Med. Times*, May 11, 1878, p. 375.)

**Abnormal sweating of the hands following suppression of that of the feet.**—HILDEBRANDT reports the case of a soldier who dusted salicylic acid, combined with starch and talc, on his feet seven times during three weeks to suppress the abnormal perspiration. The latter ceased temporarily, but recurred during marching. The powder was reapplied twice, after which the palms of the hands perspired profusely, so much so that the water ran in streams from them, whilst there was scarcely any sweating of the feet, although he was on a prolonged march during hot weather. The other portions of the body were, at the same time, quite dry. The same phenomenon was also observed in another soldier who used this powder, though the perspiration of the feet did not cease entirely.—*Deutsche Med. Wochensch.*, 1877, No. 20; *New York Med. Journal*, August, 1878, p. 210.

**Chromidrosis.**—DR. ANDREW H. SMITH reported a case of chromidrosis to the New York Pathological Society, in which the sweat from one axilla stained the clothing an orange color; it was readily removed by washing. That of the other axilla yielded a dark stain, which was permanent.—*New York Medical Journal*, July, 1878, p. 73.

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#### NEW FORMATIONS.

EDWARD WIGGLESWORTH, M.D.

**Treatment of nævi by multiple scarifications.**—Following Balmanno Squire, VIDAL has removed from the face and body various abnormal growths by means of scarification; large nævi diminished in size and small ones disappeared under this treatment from obliteration of vessels and cicatricial formation. After the fourth scarification, and at times earlier, the part operated on appears of a rosy, instead of a purplish-red color as before. Next, small islets form in the nævus, which soon assume the color of healthy skin. Best of all, the scarified tissues show often, after complete cure, no signs of a scar. For the operation, Vidal recommends small lancet-shaped needles, with which several incisions, 1-1½ mm. in depth, are to be made. Deeper incisions may give rise to scars. The scarifications should be parallel and 2 mm. apart, and new ones should be made parallel with the earlier ones, as soon as these latter have healed. Small nævi may be cured in one sitting; larger ones, especially upon the face, need several. The drawbacks are pain and bleeding. For the former, local anæsthetizing may be employed, and even this is not always needed. For the bleeding, touchwood or German tinder may be employed; liquor ferri is rarely required. Should the patient feel the loss of blood, the intervals between the operations may be extended. When the bleeding has ceased it is well to wash the parts with a fine, moist brush, to prevent clotting in the incisions. Vidal has, in several cases, needed twenty sittings for a single nævus, and considers that the result more than compensates him for the time and

trouble.—*Jour. de Méd. et Chir. Prat.; Annales de la Société de Gand, V Livraison, 1878; Allg. Med. Centr.-Zeitung, 14th Sept., 1878.*

**Treatment of lupus by scarification.**—DR. LELONGT, in his thesis upon the pathological anatomy of lupus and its treatment by linear scarification, compares the merits of this method of Vidal with those of the treatment, by scraping, of Volkmann. Dr. T. Veiel was the first to employ the former method. Dr. B. Squire has conjoined both with advantage. Vidal adopts Veiel's method with good success. It does not prevent relapses; it does arrest the course of lupus, and cause its disappearance in a comparatively short time. The skin is locally anaesthetized; then, with a needle like a cataract needle, linear parallel incisions are made as close to each other as possible. Similar cross-cuts are then made, leaving the skin divided into lozenges about 2 mm. broad. These incisions must penetrate the whole thickness of the skin, a rule which it is easy to observe, as the sound and diseased tissues differ markedly in consistency. The whole surface is to be thrown off, so there need be no fear of making too many scarifications. Hemorrhage is inconsiderable. Iodoform is then every morning powdered upon this cut surface, which cicatrizes in a week, when the process may be repeated. Every lupus nodule requires, on an average, six or seven such scarifications. The scar is flat and slightly depressed, and its redness gradually diminishes. The dermatologist must be ready to repeat the operation the moment signs of a relapse appear. Dr. Lelongt thinks that the subacute inflammation set up in the neoplasm destroys the old, or possibly segmenting, cells, while the embryonic ones with the connective tissue are stimulated to the formation of a cicatrice. This method is adapted to ulcerative and to erythematous lupus. Large surfaces must be treated by small, distinct islands, one at a time, which should be at first in the periphery of the patch, thus arresting more speedily the progress of the disease. This method, as well as that of the curette, have each their advantages; the latter, however, would seem preferable for hypertrophic lupus or where the formation is considerable. The cases in which each is superior can only be decided in due course of time, when the relapses and cicatrices have been more studied.

Du lupus, anatomie pathologique et traitement par la méthode des scarifications linéaires, par le Dr. Lelongt. *Thèse de Paris, 1877; Ann. de Dermatologie et de Syphiligraphie, t. ix., No. 4, 1877-78.*

**Clinical distinction between gummata of the skin (*lupus syphiliticus*) and *lupus vulgaris*.**—ZEISSL admits the slight difference, microscopically speaking, between gummata and the nodules of *lupus vulgaris*, but schematizes as follows the clinical differences for purposes of diagnosis:

## GUMMATA (SYPHILITIC) OF SKIN.

Localized granulation tumors of different sizes, causing caries and necrosis of bone and cartilage.

Location, cutis or subcutaneous cellular tissue.

Painful on pressure.

Commonly accompanied with ozaena syphilitica.

Large and deep scars remain.

If due to inherited taint, the velum palati is generally ulcerated.

## LUPUS VULGARIS.

Small, disseminated, reddish-brown nodules, which exfoliate. Intervals infiltrated.

Peripheral reaction, or ulceration, or erysipelatous swelling.

Nodules and ulcers nearly painless.

Bone of nose commonly unaffected.

Usually tendinous cicatrices.

Generally no ulceration of the velum.

Reprint from the *Annual Report of the Vienna Gen. Hospital* for 1877.

**Spedalskhed (Norwegian leprosy).**—DR. RABE, having visited Norway, lectured upon leprosy before the Physiological and Therapeutical Association of Dresden. He regards lepra as a disease *sui generis*, but modified by climate, race, general customs, and personal habits. It is to be distinguished from radesyge, from the Ditmarschisch disease, and from scarlievo, all of which are of syphilitic origin. The prognosis is absolutely unfavorable, death almost invariably occurring after prolonged illness, though deferred by good treatment, change of climate, etc. The tubercular form rarely lasts more than nine years, the anaesthetic from six to twenty-four. Death may be speedy from pyæmia. In a few cases the disease-process has arrested itself, and the ulcers have cicatrized. Of the many thousand lepers treated during the last fifteen years in the three hospitals at Bergen, only fifty-six can be called cured. The etiology is very doubtful. Norway has the greatest per cent. of lepers of all the countries of the world. Still, it is relatively diminishing, while the population, in spite of emigration to America, is increasing. The whole country is districted, each district has a physician who visits it, hunts up the lepers, sends them to the hospitals, and a list of them to the government, which, in spite of its poverty, spends annually large sums for the relief of such unfortunates. Twice a year the general inspector makes a tour of the whole country. Lepra is an endemic disease, and confined at present, in Norway, to the west coast. Lepra is hardly acquired, nearly every case being traced to hereditary taint, and this is more often from the mother than from the father. Atavism is not uncommon. Danielssen has seen lepra transmitted to the fourth generation. It rarely occurs before the sixth year, and usually not until after puberty. Where occurring in childhood, it interferes with subsequent sexual development. It is more common in men than in women. It rarely appears, primarily, after the fortieth year of life. If inherited, it occurs before puberty; if acquired, later. The poison must work for years upon a healthy person before the disease becomes apparent. Some authors hold that it is the predisposition to lepra and not the disease itself which is inherited.

Boeck found lepra in the descendants of leprous Norwegians who had emigrated to America many years before. Danielssen thinks there is some connection between lepra and tuberculosis.

How the first case originated in Norway is not known. The disease was there before the crusaders returned from Palestine. How to relieve the present cases is an equally doubtful matter. There is no specific against lepra. Emigration gives the best results. The next best come from proper hygienic conditions. Cleanliness and soothing applications locally are of service, and subcutaneous injections of morphine for pain. Every internal remedy ever suggested has been tried at Bergen with equal lack of success.—*Arch. der Heilkunde*, 15 June, 1878.

**Leprosy in Spain.**—A correspondent of the *France Médicale* writes from Madrid in October, 1878, that leprosy has appeared in various districts of Alicante, calling even for the erection of special hospitals. In Valencia, during one year, one hundred and sixteen cases of leprosy occurred; of these, seventy-one were fatal; of the non-fatal cases seventeen were women. Moreover, a majority of the cases were probably never brought to light: since those attacked endeavor in every way to hide the fact from even their nearest relations, as something disgraceful. The disease goes by the title, now of "the Moorish disease," now of "the disease of Saint Lazarus." In Valencia and Alicante the malady appeared under two forms: "the tubercular or lepra Græcorum [!—REP.], and the usual lepra anæsthetica or lepra Hæbrorum." Recovery "very rare." There is a special hospital for lepers, near Valencia, and patients refusing to go there are isolated, and subjected to the strictest hygienic regulations.—*Allg. Wien. Med. Zeitung*, Oct. 29, 1878.

**Leprosy.**—DR. J. LABOUTÉ, of Mauritius, gives, in an admirably terse and comprehensive paper, several cases of leprosy. The anæsthetic variety is the less repulsive, lacking the crude and suppurating tubercles and the leonine appearance of the face, characteristic of the tubercular form. It is, however, as severe in its effects, the patient being almost invariably rendered helpless. When it first sets in, bullæ show themselves, principally on the hands and feet, fingers and toes, where, after a short time, they burst and leave behind ulcers, which usually heal more readily than in the other form, except those which are on the plantar aspect of the foot. Accompanying this there is numbness, varying in degree and extent, and, if a close inspection be made at the time, there will be invariably found upon the extremities discolored patches of skin of a dull white or waxy yellow hue, having, in some instances, a scaly appearance, and in others a sort of metallic lustre. Like patches are not uncommonly met with upon the face also. Muscular atrophy, which, perhaps, is the earliest symptom in this form, is now apparent, and progresses steadily, involving principally the extensor muscles of the hands. First the little and ring fingers are flexed,

then the remaining ones: flexion beginning at the distal phalanx, and extending gradually to the second and first, the hand thus becoming unserviceable. Ulceration at the joints may cause the phalanges to fall off, reducing hands and feet to mere stumps. So great is the waste of muscular tissue that the palm of the hand is soon converted into a cavity of skin and bone, the inner and outer borders closely approximating. Muscular atrophy is not general in all cases, but is mostly confined to the extremities. The countenance, as a whole, is seldom much altered, except where, from paralysis, there is eversion of the lower eyelid with epiphora and photophobia, and dragging of the face to one side with wrinkling of the skin, as in old age, due to muscular atrophy.

Blindness may, exceptionally, supervene. Appetite, sleep, and general health may be satisfactory even to the patients. Other special senses are rarely affected. Hair and eyebrows may fall. This form occurs in both sexes, irrespective of age, and develops more slowly and with less suffering than the tubercular form; spontaneous cures being also more frequent. The two forms may be "mixed" upon the same patient, or a parent may have one, the offspring the other. Pigmentary changes occur from possibly some impairment in the functional activity of the vaso-motor system of nerves. The disease is not only hereditary, even atavism is shown by one case where the offspring (a girl) of one of a patient's brothers, a stout, strong man in perfect health, married to a woman equally stout and healthy-looking, took on the disease at the age of eight years.—*Edinb. Med. Journ.*, Nov. 1878.

**Nerve-stretching in anæsthetic leprosy.**—DR. E. LAWRIE, of the Bengal Medical service, reports, in the *Indian Medical Gazette* for September, the case of a man, aged 40, who was admitted into the Medical College Hospital at Calcutta, on July 1, with anæsthetic leprosy. On admission there was complete loss of sensation all over the patch; the patient could only grasp feebly with the right hand, and the ulnar nerve was very much thickened from below the inner condyle of the humerus to about half-way up the arm. The nerve was stretched the same day under chloroform.

No regular notes of the case were taken afterwards. The patient attended very irregularly, and would never admit that his condition was improved, though the affected skin became visibly healthier. After a long interval he presented himself on August 5, and it is recorded that "the skin of the hand and forearm is uniformly healthy; sensation is perfect throughout the area that had been anæsthetic; and the thickening of the ulnar nerve has entirely disappeared. The patient admits that the tingling and pain no longer trouble him, and that his hand is much stronger."

Dr. Lawrie has stretched the ulnar nerve in about thirty cases of anæsthetic leprosy. In every case the operation was followed by benefit, as far as the area supplied by this particular nerve was concerned, which appeared to be permanent. The patients ceased at-

tending the dispensary whenever the relief they experienced seemed to them decisive, and therefore no notes of their final condition were obtainable, except in the present instance.—*Lond. Med. Record*, Nov. 15, 1878.

**Anæsthetic leprosy.**—TILBURY FOX reports the case of a boy of seventeen, of English descent, born in Bombay. No hereditary taint. Disease began, at the age of 11, as brown marks in patches on body, limbs, face, hands, and feet, without subjective symptoms. Previous health good. Treated by Dr. Bhan Daji, with some essential oil, externally and internally. After several months he became ill, his strength left him, his hands, feet, and face swelled, and sores broke out upon his legs. He gradually recovered, and after two years seemed quite well, except some disordered sensation and numbness about the elbows and right ear. He then came to England, where he has always lived well, and the lepra for about three years and a half remained in a quiescent state. At present he suffers from an acute recurrence of the disease (leprasis), beginning two or three months ago as a brownish discoloration about the cheeks and nose. These spots are now generally diffused over the skin, and are not mere maculations, as in the former attack, but exhibit distinct structural changes in the skin texture. Other symptoms, as at first, of eruption, with slight deposit in skin, of nerve lesion (knotty state of superficial nerve-trunks), and anaesthesia in circular blotches, dry, scaly, and withered, with dirty-white or faint-red centres, and more conspicuous, reddish-yellow, well-defined, semi-psoriatic-looking edges; bullæ also on the feet. The progress of these cases is always slower than that of those of the tubercular form. There is no specific for lepra. The disease may be ameliorated by the use of Cashew, Gurjun, or Chaulmoogra oils. Patients should leave climates where lepra is endemic for temperate and bracing ones. Hygiene is of the greatest importance. Fox has faith in the value of quinine, pushed to extreme doses; mineral acids and chlorate of potash, with Gurjun oil, inflicted twice daily.—*Medical Times and Gazette*, Dec. 21, 1878.

**Chaulmoogra oil in the treatment of leprosy.**—Dr. DAVID YOUNG reports six illustrative cases out of between fifty and sixty treated for leprosy at the Mission Hospital, Bombay, during eighteen months. The patients were all adults, the proportion of males to females about three to one. The treatment was by Chaulmoogra oil alone, or combined with the tincture internally, or a liniment externally, of psoralea corylifolia, a leguminous plant abounding in the Konkan and Deccan. The forms of leprosy noted were: macular, four; anæsthetic, twenty-three; tubercular, fifteen; mixed, eleven. Out of the six cases reported but one obtained no apparent benefit. The other five, after a treatment of from six months to a year, were all improved in health, with an increase in weight and more or less new growth of hair. Dr. Young sums up as follows:

I. In the macular and in the early stage of the anæsthetic forms of leprosy, the Chaulmoogra appears to be of decided value.

II. The oil should be given at the outset in small doses and gradually increased, as otherwise it is apt to cause nausea.

III. The good results were seen earlier in those cases in which the powdered seeds were given instead of the oil.

IV. A liberal milk diet seemed to be a valuable auxiliary.

V. The psoralea given internally, in combination with the oil, appeared to be of no value, but when applied externally in the form of a liniment, was of undoubted service, especially in stimulating the hair bulbs.

VI. Several of the cases treated were complicated with bronchial affections, which were quite relieved during the treatment. This, taken in connection with the fact that all the patients gained flesh, may point to the probable usefulness of the oil in affections of the chest.

VII. The oil has a deserved reputation in cases of itch and parasitic pediculi, and forms a valuable addition to the ordinary sulphur ointment.—*The Practitioner*, Nov. 1878.

**Multiple melanotic [?—REP.] sarcoma of skin.**—In the reports of the Toronto General Hospital occurs a very brief account of a case of multiple sarcoma. A man of sixty-four, reporting a cousin with cancer of the breast, noticed thirty years ago (say in 1847) a black, pin-head sized papule an inch to the left of the navel. In the summer of 1876 it became as large as a currant. In the fall of 1876 it became chafed, “discharged blood, and burst through the skin,” and increased in size, having been cauterized. In the spring of 1877 it was strangulated with horse-hair, but grew again, uniting with three adjoining tubercles of a similar character, which also appeared at this time, to form one large tumor, which measured, November 20, 1877, 10 by 5 by 3.75 cm., was soft, fungoid, and though non-discharging, of a most offensive odor, causing even gastric disturbance. Slight lancinating pains at times. Early in October, 1877, some two hundred movable and immovable, hard, colorless tubercles, from pea to cherry-size, formed under the integument all over the body, “those situated near veins, of a pinkish color, and some of these have burst through the skin.” General health otherwise good. The large tumor was removed by Dr. Aikens by means of the galvanic cautery, and the patient has since been progressing favorably without the aid of medicines. Portions of the tumor under the microscope showed the characteristic round and spindle-cell formation of sarcoma in parts, with some pigmentation.—*Canadian Journ. of Med. Sci.*, vol. iii., No. 2, p. 58.

**Rodent ulcer.**—THIN has examined, microscopically, a cancerous ulcer of forty-three years’ duration, combining the chief features characteristic of rodent ulcer, which was removed by excision by Sir James Paget, at which time it covered the whole scapula; and, also, a rodent ulcer, measuring three by four inches, removed with

the knife by Mr. Morrant Baker. Under the border of the ulcer, in both cases, and for a very small distance under the epidermis of the margin, clusters of cells separated the bundles of connective tissue, and grew most luxuriantly towards the surface. The clusters were largest in the upper strata of the cutis, and caused the progressive ulceration by obliterating the connective tissue and blood-vessels of the papillary layer. The centre was composed in each case of a substratum of unaltered connective tissue of the cutis, covered by an amorphous substance containing blood-vessels and large numbers of colorless blood-cells. Sparsely scattered through this tissue were patches of the above-mentioned cell-clusters. In the sections examined, the only changes found in the rete mucosum, sebaceous glands and hairs, were retrogressive, thus contrasting with what is found in epithelioma. Diseased sweat glands were not found. The results of these examinations show that in some, at least, of the cases distinguished by the name of rodent ulcer, we have to do with a special pathological condition having no near relation to epithelioma. Paget's case resembles the one described by Verneuil, in which the departure of morbid action was definitely traced to the sweat glands; this, and the evidences of a tendency to new cell-formation in the sweat glands, observed in the former one, points to the strong probability that the rodent ulcer, of English surgeons, and the adenoma of the sweat glands, of the French surgeon, are one and the same disease.—Reprint from the *Transactions of the Pathological Society of London*, for 1878.

**Differential diagnosis of multiple carcinoma and of sarcoma melanodes from gumma syphiliticum.**—ZEISSL summarizes as follows the distinctions between gummata and carcinomatous formations:

GUMMA SYPHILITICUM.

Most common on face and extremities.  
Nodules frequently reabsorbed.  
Ulceration frequent.  
Microscope shows a scanty, mucilaginous, intercellular fluid. The tissue approximates to that of the embryonic state.

MULTIPLE CARCINOMA. SARCOMA MELANODES.

Most common on trunk, rare on face.  
Reabsorption very rare.  
Skin generally remains intact.  
In multiple carcinoma, a white, black, or speckled medullary mass; in sarcoma melanodes, elementary fibrous tissue loaded with pigment.

Reprint from *Ann. Report of the Vienna Gen. Hospital*, for 1877.

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## HÆMORRHAGES AND NEUROSES.

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**A case of recurrent cutaneous hæmorrhage with urticarial and bullous efflorescence.**—DR. JAMES C. WHITE gives notes of the following case. The patient was a healthy woman of 39. The disease had first appeared four years previously, since when it had recurred regularly three or four times a year, each attack lasting six or eight weeks. For the first two years the disease was confined

to the hands and feet, but later it was more widely distributed. When seen the attack had lasted already three weeks. The forehead was of a deep violet-black color, as if badly contused, the discoloration being separated from the healthy skin of the cheeks and lower temples by an abruptly-defined, irregularly-curved outline, as if the disease were making a serpiginous progress downwards. Within this dark field the skin was infiltrated in patches, and presented also numerous excoriated points. The rest of the face and the ears were deeply reddened, and showed irregularly-circular areas of infiltration of various sizes, slightly elevated and excoriated, which also exhibited haemorrhage effusions of different shades of color. The neck was in a similar state.

The palms of the hands were occupied by numerous bullæ, ranging in size from a pea to a nutmeg. The contents of the smaller were serous, of the larger ones more or less sanguinolent. Some of them were discharging a bloody fluid. Intermingled with these bullæ were large haemorrhagic patches of elevated infiltration, and excoriated surfaces, the seats of former bullæ, still oozing or covered with sero-sanguinolent crusts. The forearms and lower legs from the knees down, parts which had only become affected within a few days previously, exhibited a sparse eruption of urticarial wheals, circular erythematous patches, and small bullæ, a considerable proportion of all of which were becoming somewhat haemorrhagic in character. The skin elsewhere was entirely healthy. The sensations in the parts affected were great itching and burning in the primary forms of eruption, and soreness of the excoriated surfaces. Her general condition was very good, as before the attack, and it continued to be so, excepting the lassitude and nervous exhaustion in consequence of loss of sleep dependent upon the subjective symptoms. Dr. White watched the course of the disease closely during a week. He found that circular erythematous patches or well-defined wheals, from pea to half-dollar size, first appeared, and remained unchanged for twenty-four hours. Then some of the erythematous patches would assume the form of pomphi, some of the original wheals would subside into blotches of erythema, while some of both kinds of efflorescence would become bullous in character. Within forty-eight hours all these multiform lesions would become more or less haemorrhagic, varying in tint from a bright arterial scarlet to the deepest purple-black, while large surfaces of intermediate and surrounding skin appeared as if stained by the severest contusion. The subsequent changes were very slow. Some of the bullæ would increase in size, and so fill as to contain half a wine-glass of bloody serum; others would rupture under the scratching which the intense itching provoked, and become oozing surfaces; while upon these, as well as upon other forms of excoriation, sero-haemorrhagic crusts would form. Upon the palms and soles the efflorescence was wholly bullous, and upon the latter the bladders attained great size later in the attack, and prevented walking for ten days. The disease extended downwards as far as the chest,

upon the arms upwards nearly to the shoulders, and from the feet half-way up the thighs. The rest of the surface remained perfectly healthy. There was no apparent affection of the mucous membrane anywhere.

The patient was under observation a month. No remedies seemed to affect the course of the attack, which, like previous ones, lasted seven weeks. The changes in the cutaneous tissues diminished rapidly in intensity after the last outbreak of the large bullæ upon the palms and soles. The latter also healed rapidly. No pigment stains were left to mark the seat of any form of efflorescence. (Presented at the second annual meeting of the American Dermatological Association, Aug. 29, 1878.)—*Boston Med. and Surg. Jour.*, Oct. 10, 1878.

**A contribution to the history of purpura complicated by albuminuria.**—MESLIER says that the albuminuria which accompanies purpura is sometimes that form characterized by alteration in the blood, where the albumen seems to pass from the blood, through the renal filter, intact; at other times is caused by transitory catarrhal nephritis, or by Bright's disease. He gives an illustrative case. It was that of a child of six, who had an attack of measles. About the end of the second week of the disease, a few scattered patches of purpura showed themselves on the legs and trunk, the nose bled a little. During the next succeeding days the purpuric patches spread and the epistaxis continued. The patient complained of pain in the limbs. No fever. The urine was very albuminous. Six days later, diminished epistaxis, no more petechiæ, general anasarca. By the end of a month the patient was quite well.—*Bull. Gén. de Thérap.*, 1878, p. 220.

**Pruritus vulvæ treated with sulphurous acid.**—Under this title DR. EDWARD B. STEVENS describes a case of pruritus and eczema of the female genitalia, due to leucorrhœa originating in a small polypus of the os uteri.

The polypus being removed, the leucorrhœal discharge ceased. For the pruritus and burning S. directed the parts to be freely bathed with sulphurous acid *in full strength*. The result was prompt and entire relief. Subsequently there was a partial return, on several occasions, of the rash and pruritus, but always completely and promptly relieved as at first by the free application of the sulphurous acid.—*The Obstetric Gazette*, vol. i., No. 4, 1878.

**Diabetes and pruritus vulvæ.**—DR. E. MONTGOMERY has observed a number of cases of diabetes in which pruritus vulvæ was an annoying concomitant. He thinks that in the early stages of those cases of diabetes characterized by glycosuria and polyuria, he has noticed most happy results from a few drops of the tincture of iodine in two ounces of water, three times a day, and pills composed of strychnia, phosphorus, and iron, at bedtime. Externally

he uses liq. potas. permanganate and an ointment of salicylic acid.—*St. Louis Med. and Surg. Jour.*, September, 1878.

**Pruritus vulvæ.**—DR. T. GAILLARD THOMAS, of New York, in a clinical lecture on this subject, alludes to diabetes mellitus as a not uncommon cause of pruritus. Scabies of the mons veneris and neighboring parts is another cause, and, in examining the patient, the surface of the skin should be carefully looked over with a magnifying glass, in order to discover any burrows of insects which may be present.

The importance of getting at the cause of the pruritus cannot be over-estimated. Leucorrhœa is usually at the bottom of the trouble, and this of that peculiarly acrid variety which causes stinging of the finger after a vaginal examination, or which gives rise to urethretis in the male (after connection), which can only be distinguished from that of a specific character by its short duration and easy curability. If in any case it is desired to test whether vaginal leucorrhœa is the cause of pruritus, the vagina may be thoroughly tamponned with cotton, which should be saturated with glycerole of tannin. If it is really the cause, this mere damming up of the discharge will make the matter clear; for in twelve hours the patient will experience the greatest relief from her suffering.—*Phila. Med. Times*, July 20, 1878.

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II.

SYPHILIS AND VENEREAL DISEASES.

GENERAL QUESTIONS IN SYPHILIS, THERAPEUTICS,  
ETC.

E. L. KEYES, M.D.

Note on a case of pulmonary syphilis, followed by reflexions upon visceral syphilis, and the errors of which it is the object.—LANCERAUX arrives at the following conclusions as embodying a summary of the views expressed in his paper :

1. Syphilis, if exception be allowed to the fever attending the beginning of the secondary manifestations, shows itself invariably by material lesions of the organs of the body, and by functional troubles proportionate to the seat and extent of these lesions.

2. This malady always primarily affects the tissues derived from the middle layer of the blastoderm, and in particular the elements of the lymphatic system.

3. It shows itself by lesions of slow development, of which the type is embryonal connective tissue, and which sometimes disappear by absorption or elimination, sometimes become organized into different homologous tissues (bony tissue in bone ; lymphatic tissue in the glands ; cicatricial tissue in connective tissue).

4. It develops in three periods :

The first period is characterized by one or more local accidents called chancres.

The second by lesions, or eruptions disseminated, spread out, superficial and resolvent,—that is to say, lesions which disappear without leaving any trace (generalized eruptions of the secondary period).

The third by lesions deep and circumscribed, which leave behind them a loss of substance, a more or less thickened and callous cicatrix (circumscribed eruptions of the tertiary period).

A knowledge of this evolution serves to fix the moment of cure of syphilis, which, as is the case in all maladies of definite type,

may become completely arrested at the end of one of its natural phases.—*Annales de Dermat. et de Syphiligraphie*, 1877, 1878, No. iii., p. 153.

**Differential diagnosis between epithelioma of the tongue and tertiary syphilitic glossitis.**—FOURNIER formulates this as follows:

ULCERATIVE EPITHELIOMA OF THE TONGUE.

1. Occurs in adult age; most frequent between 50 and 70.
2. Hereditary predisposition; antecedent syphilis only by coincidence.
3. Lingual psoriasis has often preceded the outbreak.
4. Commences externally as a hard superficial node, followed by more or less rapid surface ulceration. No central suppuration, no excavation.
5. May appear on the under surface of the tongue.
6. With rare exceptions, the lesion is single, unilateral.
7. The lesion is a tumor, ulcerated on its surface.
8. Edges everted, border raised, unequal, irregular, excavated, etc.
9. Surface bleeds on being touched, or spontaneously.
10. Discharge free; towards the end fetid and ichorous.
11. Pain spontaneous, lancinating, sometimes shooting toward the ear.
12. Functional troubles marked; tongue immovable; speech, mastication, deglutition, salivation, etc., difficult.
13. Lesion finally gives rise to general symptoms of cachexia.
14. Microscopic examination shows epitheliomatous structure.
15. Lymphatic glands affected after a time.
16. Uninfluenced or hurt by antisyphilitic treatment.

ULCERATIVE GUMMA OF THE TONGUE.

1. Usually occurs at a younger age than cancer.
2. Syphilitic antecedents; no tendency to cancer excepting by coincidence.
3. No preceding lingual psoriasis.
4. Commences as a hard nodule under the surface; suppurates centrally; an excavation remains, attended by rapid ulceration.
5. Occurs exclusively on the dorsum and sides of the tongue, never beneath.
6. Lesion sometimes multiple and bilateral.
7. The lesion is an ulcer without a tumor in a strict sense.
8. Edges deeply excavated, sharply defined, adherent.
9. Floor of ulcer sloughy, not tending to bleed.
10. Discharge slight, not ichorous.
11. No spontaneous or darting pain.
12. Functional troubles less marked than in cancer; tongue not immovable, or not so much so as in cancer.
13. Lesion itself does not give rise to cachexia.
14. Microscope shows the characters of degenerated gummatous hyperplasia.
15. Ganglions not involved.
16. Antisyphilitic treatment beneficial.

*Journ. des Sci. Méd.*, 1878, p. 510; *Phys. and Pharm.*, Feb. 1879, p. 69.

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#### SYPHILIS OF THE NERVOUS SYSTEM.

E. C. SEGUIN, M.D.

**Syphilitic monoplegia.**—Dr. PROUST reports the case of a man aged 46 years, who suddenly experienced pain in the left arm. This was rapidly followed by paralysis and anaesthesia of that extremity, the sensory and motor symptoms being most marked in the distribution of the musculo-spinal nerve. Shortly afterwards it

was noticed that the radial pulse did not beat, and that the arm and hand were colder than the same parts on the right side. Two months after the development of these symptoms, Dr. Proust verified their existence, and found besides some atrophy of the affected hand. The grounds for believing the man to have been syphilitic are not given in the abstract, but it is stated that great improvement was obtained by means of mercurial inunctions and large doses of iodide of potassium.—*Bull. de Thérapeutique*, 1878, April 15, p. 327.

**Syphilitic disease of the spinal cord.**—Dr. S. G. WEBBER, of Boston, read a communication on this subject at the last (fourth) annual session of the American Neurological Association. The patient, a male, had partial general paralysis, with numbness and severe pains in the extremities, and retention of urine. There were also numbness in the side of his face, and ptosis in the right. Dr. Webber did not make the autopsy, and received only the diseased spinal cord. The greatest change in the cord was found just below the cervical enlargement. The membranes opposite the lateral columns were thickened and adherent; central gray substance deformed. The centre of the cord was occupied by a mass of diseased tissue, in which were seen numerous vessels with nuclei and much fibrous tissue; also many enlarged cells, some secondary degeneration in right lateral column, and traces of independent sclerotic changes in the posterior columns. Chief peculiarity of lesions was the enormous increase of apparent spider-cells.—Proceedings of the Association in *Journal of Nervous and Mental Disease*, July, 1878, p. 504.

**Syphilitic arteritis, thrombosis, and hemiplegia.**—Dr. RAMSKILL relates with satisfactory details a very valuable case of this sort. The patient, a male, of middle age, contracted syphilis, had eruption, alopecia, and severe headache. At time of entering hospital was perfectly bald, bore some symmetrical copper-colored, scaly patches, and suffered from severe pain in the head. One morning was found with palsy of the right side and right hemianesthesia; speech lost; vision not much impaired; but ophthalmoscope shows choroido-retinitis. Full inquiry seems to show that hemiplegia did not develop suddenly. During the days that the patient survived his temperature seldom reached 100 degrees, and his pulse was normal. There was deviation of the eyes and head toward the left shoulder (toward the injured hemisphere); Cheyne-Stokes breathing at the last. The autopsy showed softening of the left anterior lobe (convolutions not given); thickening and thrombosis of the left anterior and middle cerebral arteries. No tumor or nodes.—*Medical Times and Gazette*, Nov. 24, 1877, p. 566.

**Syphilitic hemiplegia.**—Under this heading, Dr. GIRALT, of St. Vincent's Hospital, New York, reports a case of common hemiplegia in a male aged 31, who probably never had syphilis. Even if he had this disease, there is nothing whatever in the history of

the case to show that it was not one of cerebral hemorrhage occurring at a rather early age. It seems a pity that the epithet *syphilitic* is applied so freely to all nervous symptoms which appear in a subject who has had syphilis.—*The Hospital Gazette*, July 4, 1878, p. 14.

**Syphilitic paraplegia.**—Two cases exhibiting the well-known symptoms of spinal congestion, motor paralysis, paresis of the bladder and rectum, pains in the limbs, no disorder of sensibility, variability in symptoms, are reported by PHILIPSON. The subjects are said to have had "syphilis," five and seven years before the paraplegia, respectively, but no syphilitic symptoms are specified; the inguinal and cervical glands were enlarged. Both cases rapidly got well under iodide of potassium, in doses of ten grains three times a day, and upon these slight data the diagnosis of syphilitic spinal congestion is made! The author seems to have implicit faith in the notion that a disease which proves amenable to iodide of potassium is syphilitic,—a doctrine which we think will bear revision. It might be added that in our experience syphilitic paraplegia has not been congestive, but of the sort indicating severe myelitis or compression by a gumma.—*Lancet*, March 30, 1878, p. 458.

**Syphilitic meningitis, or gummy tumor.**—This heading in one of Professor DA COSTA's clinical lectures is followed by the relation of a case in which certain basal paralytic symptoms are hastily attributed to syphilis; the patient having had syphilis many years ago, "but not in an unmistakable form." As treatment by iodide of potassium was only begun after the delivery of the lecture, we have no result to aid in the diagnosis. (It would seem better not to apply the epithet *syphilitic* to such imperfect cases.)

In the same lecture a patient with right hemiplegia and passed aphasia is said to have syphilitic arteritis, which was much relieved by iodide of potassium.

(This case is in many respects instructive, but the reporter must take exception to the statement that syphilitic arteritis produces *congestion*. Inasmuch as the calibre of the affected artery is diminished by this disease, even to complete obliteration, or to the formation of thrombus, it follows that the tissues supplied by a vessel so diseased must, on the contrary, be in a state of local anæmia or ischæmia.—REP.)—*New York Medical Record*, March 16, 1878, p. 203.

**Syphilitic epilepsy.**—A male aged 28 years admitted to Hôpital St. Louis, on February 2, 1878. At age of 20 had a chancre followed by buccal "erosions" and enlargement of one testicle. In November, 1877, had for one month localized pain in the right fronto-parietal region, not clearly worse at night. One month before admission experienced an attack consisting of sudden numbness in the left leg, then in left arm and left side of face; at same

time heard a dull sound in his ears, but did not fall down or lose consciousness. The attack was over in a few moments. In a week a second seizure occurred, more severe; characterized by left-sided numbness, convulsions of left face and limbs only, loss of consciousness. Third attack, eight days before admission, consisted of spasm on the left side and loss of consciousness. On the day before entrance into hospital had a seizure consisting only of tremor of the left limb. Examination showed no evidence of syphilis; weakness and slight ataxia (?) of the left leg; no anaesthesia. Treatment consisted of inunctions of mercury, and seventy-five grains of iodide of potassium per diem, continued until March 25. Slight attacks occurred on February 6, and on the 12th.—CHUQUET, in *La France Médicale*, Sept. 17, 1878, p. 521.

**Syphilis as a cause of aphasia and of locomotor ataxia.**—At a meeting of the Medical Society of London, held April 15, 1878, Dr. DRYSDALE read a paper upon the above subject with reference to the well-known and undisputed subject of syphilitic aphasia. Dr. Drysdale made the interesting statement that it often coincided with left hemiplegia. Syphilitic aphasia without bodily paralysis was also mentioned. The loss of speech often appears in the secondary period of syphilis.

With reference to the second point, the author agrees with A. Fournier in believing that some cases of locomotor ataxia are syphilitic. He founds his opinion upon the fact that syphilis is often found as an antecedent to ataxia, and upon the notion that syphilis causes sclerosis in other organs. He does not, however, cite any case of the disease cured by anti-syphilitic treatment.

(This last question is one in which the reporter is especially interested, and which he hopes to have an early opportunity of discussing upon the basis of his personal experience. We are absolutely opposed to the doctrine of syphilitic sclerosis of the posterior columns of the spinal cord.—REP.)—*Lancet*, May 4, 1878, p. 647.

**Syphilitic arteritis.(?)**—At a meeting of the Imperial and Royal Medical Society of Vienna, held April 12, 1878, Dr. KÖNIGSTEIN exhibited a patient with anaesthesia of the right side of the face, paralysis of all the muscles of the right eyeball, leucoma of the cornea, great atrophy of the right optic disk, and commencing atrophy of the left. The man had had chancre, condylomata, headache, loss of smell, and epileptiform attacks. No results of treatment are mentioned.

The reporter has seen two similar cases, and looked upon them as instances of basal meningitis; they all recovered under anti-syphilitic treatment and galvanism.—*London Medical Record*, June 15, 1878.

**Insanity with remarkable hallucinations of hearing.**—This interesting case is reported under the title of “cerebral syphilis,” but in the absence of a microscopic examination some doubt

must, we think, exist as to its specific nature. The patient had dementia, occasional sudden attacks of fury, was constantly annoyed by imaginary voices, sometimes of enemies, sometimes of advisers; he had severe headache at times; but no external symptom of syphilis appeared. At the post-mortem examination the lesions found consisted in a couple of patches in the large cerebral arteries, and some localized inflammation of the soft meninges, with adhesion to and slight induration of the brain substance.

During a residence of twenty-one months this patient was "regularly" given iodide of potassium in doses of ten grains three times a day, and the reporter ingenuously adds "without perceptible effect." He might as well have expected benefit from so much water. It is just such inefficient treatment of general or local physical diseases by Asylum physicians that makes practitioners hesitate about sending insane patients needing medical and surgical treatment to institutions.—*Boston Medical and Surgical Journal*, Sept. 19, 1878.

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SYPHILIS OF THE MOUTH, THROAT, AND LARYNX.

GEORGE M. LEFFERTS, M.D.

**Laryngeal syphilis.**—At the close of SECHTEM'S lengthy but interesting article on laryngeal syphilis we find the following directions for its treatment, and, as they represent the present plan in Vienna, we give them in full:

In recent and mild cases of the disease, likewise where there are superficial *plaques* in the pharynx, or erosions or slight ulcerations in the larynx, inhalations of corrosive sublimate in alcohol and water, as recommended by Demarquay and Schintzler, are used and highly spoken of. Under this treatment all the least serious of the pharyngeal manifestations quickly disappear; ulcerative processes of any extent will require, in addition, cauterization with nitrate of silver in substance.

In other cases, where secondary symptoms exist, the inhalations must be associated with the internal use of mercury,—inunctions are usually employed. In extensive ulceration of the epiglottis and of the larynx, pencillings with a solution of iodine and iodide of potash in glycerine are spoken of as being very efficacious; it is likewise of use in dysphagia caused by ulceration of the epiglottis, new growths and hypertrophies of the mucous membrane, and follicular swellings. Potash, internally, is to be used at the same time.

In perichondritis, if time be allowed, inunction over the larynx of the *ungt. cin.* and internally some preparation of potash,—a treatment which not infrequently diminishes the swelling within a day or two. If stenosis of the larynx and urgent dyspnoea are present, tracheotomy is of course a necessity.

Nervous affections of the larynx, sometimes existing with a mild catarrhal inflammation, are best treated by inhalations of chlorate of potash and insufflations of muriate of morphia. The galvano-cautery has been used by Schintzler in several instances to destroy the warty syphilitic outgrowths found in the larynx, and is recommended where pencilling with the above iodine solution fails. Finally, the various forms of stenosis of the larynx, pharynx, and trachea, due either to polypi or cicatrices, must be relieved by appropriate surgical measures.—*Wiener Med. Presse*, Nos. 27, 28, 29, 30, 31, 1878.

**On tracheotomy in syphilitic disease of the larynx.**—DR. JONES, after detailing rather minutely the history of a case of syphilitic laryngitis, on which he performed a tracheotomy with the most satisfactory results, says:

In looking up the literature of this subject I have found ample justification for the operation, not only as a means of averting imminent death, but also with a view to the aid which it brings in the cure of the condition which renders it necessary. The uniform good results which have attended it even in the most extreme ne-

cessity, as well as the warning unmistakably given by the recorded cases of death while the operation was under consideration, but before it was performed, point at once to its necessity and the danger of delay. We do not have here, as in diphtheria or phthisis, a disease for which there is too often no satisfactory after-treatment, but one for which, however terrible its manifestations, we possess a reliable remedy. By prolonging the patient's life we gain time for efficient treatment; nor is this all, for by diverting the air from the larynx we give that organ the rest which is almost necessary—often quite so—to the process of repair and cicatrization.

—*New York Medical Record*, Nov. 16, 1878.

**Syphilis of the larynx.**—As WHISTLER truly says, the study of laryngeal syphilis is recent when compared with the investigations that have been made into the manifestations of this disease in other organs, and therefore there has existed, naturally enough, until but a comparatively few years ago, a very uncertain opinion as to the lesions most commonly met with there. This is specially the case in reference to those to which special attention is called in the first lecture before us, namely, such as are connected with the early periods of the disease. These are grouped together as follows: 1. Catarrhal congestions, simulating those arising from ordinary causes. 2. Congestions accompanied by diffuse redness and swelling. 3. Mucous patches of various types. More chronic inflammation, occupying, as it were, the period of transition, the signs of which are diffuse redness, thickening, and ragged ulceration, especially of the vocal cords.

As regards congestions of the larynx in early syphilis simulating ordinary catarrhs, not much need be said. They are for the most part superficial in character, and increased redness is their chief feature. All that the patients suffer from, as a rule, is hoarseness. Occasionally, an intense redness of the interior of the larynx is met with. Such a condition is usually due to some other cause than the syphilitic poison, such as cold, excesses in drinking, smoking, etc. Such cases resemble the acute catarrhs, and are relieved by the same measures. Confinement to a room and inhalations will reduce any urgent symptoms more quickly than mercury would do without these aids. This type of laryngeal catarrh occurs at any time during the period of general eruption,—that is, during the first two years, as a rule. In the latter months of this period it is apt to be associated with thickening and other structural lesions, which then give it a more characteristic appearance. Naturally, those who have had syphilis, like others who have not, may have catarrhs of the larynx from other causes years after their specific eruptions have been cured. A fact which appears so self-evident would not be referred to were it not that patients are seen with acute and subacute congestions of the larynx, put upon mercury and iodide of potash over and over again merely because they had a history of syphilis. Frequently it dates back many years. They have kept

up this treatment for months all to no purpose. Then these remedies have been stopped, and under a non-specific treatment they have been relieved of their trouble. Now, however, reference is made to those which occur while the poison is active, and which accompany syphilitic manifestations on the body elsewhere. Without these associated phenomena the diagnosis could not be established. Even their course does not differ in many cases from catarrhs due to other causes. Greater chronicity is said to be a distinguishing feature, and certainly they often last a long while; but many non-syphilitic catarrhs of the larynx are fully as persistent, and sometimes more so, than these. They are frequently cured in a month, and almost invariably subside in three or four months at most in the more intractable cases; but, like all other specific lesions, they are liable to recur, and when left to themselves they have a tendency to increase in gravity and to become the seat of mucous patches and ulcers.

Another type of laryngeal congestion occurs precisely at the same period as the one just described, that of general eruption. In this the redness is equally diffused over the affected surface like an erysipelatous blush or erythema. No small vessels are seen running over the surface. Together with this there is swelling—or better, perhaps, puffiness—marked on the epiglottis. The redness may be general or limited; the color is rosy and somewhat opalescent; its intensity may vary; in some cases it is patchy or spotted. In these catarrhs there are no urgent symptoms of distress. The essential points which distinguish them from others associated with diffuse redness and swelling are: 1. The redness is often more limited in its distribution, and it is not so bright. It is often rosy in the earlier stages, becoming darker in cases of longer standing. It is not vivid unless accidentally inflamed. 2. They are accompanied by general puffiness instead of great swelling. 3. There are no very acute subjective symptoms. But none of these signs or symptoms will justify one in *absolutely* pronouncing the case syphilitic, if they are the only ones to go by. Fortunately, one will have the history of the case and the other constitutional manifestations to guide to a correct diagnosis, if they are looked for.

Do mucous patches or condylomata of some authors occur in the larynx? and if they do, are they at all in proportion to those appearing elsewhere? Nearly all laryngoscopists testify to having seen them (Türck, Gerhardt, and Roth, Tobold, Zeissl, Krishaber, all of whose descriptions of the appearances presented are given in the articles under review). Whistler believes that the different views respecting their frequent or rare occurrence are based upon too limited a number of cases, and that also it is an important consideration how long the case is under observation when attempting to decide their relative frequency. He is sure that, though mucous patches are rare when compared with the numberless ones on the mouth and pharynx, still they do occur more often than is allowed by some authorities (his experience is given in figures). Those

patches which most closely resemble the opalescent patches which are found upon the pillars of the fauces, upon the soft palate, and tonsils, and which therefore may be called *opalescent patches* of the larynx, occur most frequently on the epiglottis and its folds, and on the arytenoids. They affect more often the upper surface of the free border of the epiglottis. They are seen there as small oval or roundish elevations, rising gradually toward their centre, about the size of a pin's head or of a shot, of a dull whitish-gray color, not unlike the stain of nitrate of silver (which simile is often used in the description of such lesions). When situated upon the glosso-epiglottic or ary-epiglottic folds they become sometimes somewhat lacerated, and assume the more decidedly ulcerated appearance of those on the frænum of the tongue. On the arytenoids there are two forms. When situated on the posterior surface they are still flat, opalescent patches, but larger in size. Sometimes they are symmetrically arranged, and extend outward from the inter-arytenoid fold toward the ary-epiglottic ligaments. None of these attain any degree of prominence unless they become irritated. Whistler has seen them then get thickened, and stand out as red papules with an ulcerated surface, like hypertrophied patches in other parts of the body. These true mucous *papules* or *condylomata* occur also apparently without irritation, and from the very first, upon the anterior surface and upper border of the inter-arytenoid fold, upon the anterior surface of the arytenoids, and on the ventricular bands just in front of the arytenoids. When they occur in these situations they appear as circumscribed elevations or papules, firm, grayish, or reddish-gray. The summit of these papules is covered with a scanty secretion like the others mentioned. This may sometimes be brushed off, leaving a depuded surface. On the vocal cords they occur as small opalescent bodies, more or less elevated, especially when on the edges, or arranged in lines when on the upper surface. These gray streaks stand out upon the reddened cord, giving to it a mottled look, and from their form they might be called *linear patches of the cords*. Another form which they have when in this situation is a circular erosion. The color of this is red, and contrasts strongly with the whiter surface. Sometimes it is gray, with a red, excoriated-looking centre. They are all slightly above the level of the surrounding membrane. Sometimes they are prominent in their borders, with a depressed centre.

From this description it will be seen that they vary in their appearance according to their situations, and in this they resemble other mucous patches. Though differing from each other in certain respects, they have, however, one type in common, which is that in their primary stage they are all more or less papular. This would serve to distinguish them from superficial ulcers or erosions associated with ordinary catarrhs. When they ulcerate, the ulcers are more regular in outline; they are more distinctly circular and isolated than are those associated with ordinary catarrhal laryngitis, which have more the type of general erosion, with no well-marked outline.

The next affection of the larynx described is one of more chronic inflammation, in which the signs are diffuse redness, thickening, and *ragged ulceration*, especially of the vocal cords. This occupies an intermediate line between the early and later lesions of syphilis in the larynx. It may occur close in the wake of the former, and be the immediate outcome of the catarrhs and mucous patches of the larynx already described, or it may show itself three or four or more years after the primary sore. In the first instance there would be still remaining as accompanying manifestations some more or less general eruption on the skin, with mucous patches of the mouth, while in the other there may be tubercular eruptions limited to the arms or legs, periosteal inflammations or scars from ulcerating syphilitides, with ulcers of the fauces and chronic glossitis. The laryngeal ulcers are deeper than in the last class of cases spoken of; they are ragged, with thickened edges; they are small, irregular in shape, and often multiple, and the vocal cords upon which they are situated look as though pieces had been torn out of them,—still they are comparatively superficial, and are not accompanied by perichondritis and necrosis of the cartilages as are the burrowing ulcers of a later period.

The salient points of distinction between this form of laryngitis and those others with which it is most likely to be confounded, viz., the earliest inflammations of the larynx in syphilis, chronic glandular laryngitis, and specially phthisical laryngitis, are then given in the original lecture. All divisions of the subject are fully illustrated by the recital of well-selected, typical, and instructive cases, the clinical histories are numerous, and placed where they will do the most good. In the opening lecture a carefully-studied *résumé* of the earlier literature of the affection, specially in relation to the earlier manifestations of a laryngeal syphilis, will be found; the views of Troussseau and Belloc on "syphilitic laryngeal phthisis"; of Czermack, with a description of his two earliest cases; of Türck's investigations; of the important examinations and results of Gerhardt and Roth; and finally, reference to the admirable thesis of M. Dance on the eruptions of the larynx in syphilis, and to that of M. Paul Ferras on syphilitic laryngitis. The original views of these latter observers, quoted in part in the article before us, will merit a careful perusal. The question may be summed up as follows: Czermack, Türck, and Gerhardt and Roth recognize as early manifestations of syphilis in the larynx catarrhs with no very destructive appearances, mucous papules or condylomata, and superficial ulcers; while Dance considers the eruptions which he describes—roseolar, papular, and tubercular lesions—to be quite as marked here as on the surface of the body. These are the main features of every description that is found of these early lesions in all subsequent treatises. Ferras's observations have led him to oppose the view that definite lesions are found in the larynx corresponding to the chief divisions of the stages of syphilis into primary, secondary, and tertiary. He says that, since the laryngeal affection does not

correspond to that of the skin in the majority of cases, one is not justified in describing a roseola, mucous patches, or laryngeal papules, implying thereby a direct relation in the order of their appearance in the larynx and on the skin; for no lesion of the larynx, he says, could be foretold by knowing the co-existent one of the skin. He cites, in support of this, the fact that patients with advanced tertiary lesions present on laryngoscopic examination nothing but redness of the vocal cords to account for the trouble of voice from which they are suffering at the same time. He divides syphilitic laryngitis therefore into two forms, either of which may occur at any period of the disease. These are the non-ulcerated and the ulcerated: the former including hyperæmia, œdema, and hypertrophy; the latter comprising the various forms of ulcers, together with their complications, perichondritis, caries, and necrosis. As regards mucous patches—a most typical lesion of secondary syphilis—he considers them quite exceptional, if they occur at all. He does not quite like to deny their existence in the larynx, but he has only found one out of all the cases examined by him,—amounting to nearly one hundred,—taken at various stages of the disease.—*Med. Times and Gazette*, Sept. 21 and 28, Oct. 5, and Nov. 9, 1878.

#### RECENT LITERATURE.

- BARRONNE. A case of ulcerative syphilitic laryngitis, with œdema glottidis: Tracheotomy: Cure. *Il Morgagni*, Sept. 1877.
- CORNIL. Pathological anatomy of *plaques muqueuses* of the tonsils. *Le Progrès Méd.*, No. 32, 1878.
- CHUQUET. A case of gummy tumor of the posterior pharyngeal wall. *Ann. des Mal. de l'Oreille et du Larynx*, July 1, 1878.
- ETCHEBARNE. On membranoid occlusion of the glottis of syphilitic origin. *Thèse de Paris*, 1878. (La France Méd., Oct. 9, 1878.)
- HARDY. Case of chancre of the tonsil. *Gaz. des Hôp.*, No. 105, 1878.
- KRISHABER. A contribution to the study of the respiratory disturbances in the syphilitic laryngopathies. *Ann. des Mal. de l'Oreille et du Larynx*, Sept. 1, 1878.
- LAMALLERÉE. Stenosis of the larynx following syphilitic necrosis of the cricoid cartilage. *Ann. des Mal. de l'Oreille et du Larynx*, Nov. 1878.
- SCHUYLER. Tracheotomy for syphilitic disease of the larynx. *Phila. Med. and Surg. Rep.*, Aug. 17, 1878.
- SCHÜSTER AND SÄNGER. A contribution to the pathology and therapeutics of nasal syphilis. *Vierteljahrssch. für Derm. und Syph.*, Jahr v. Heft ii., 1878.

#### SYPHILIS OF THE EYE.

RICHARD H. DERBY, M.D.

**Chancres of the eye.**—THIRY believes that the ocular conjunctiva is rarely, if ever, the seat of chancre, and this he seeks to explain by the fact that the tears neutralize the virulent action of the virus. The author relates an interesting case. Patient, a man

of 23, had on the margin of the upper lid an ulceration, involving the caruncle and the lachrymal canaliculi. The lid was swollen, and there was serous chemosis. A diagnosis of phagedenic chancre of upper lid was made. The genitals showed no lesion. The patient admitted having been exposed, and remembered that four to five days thereafter he had noticed a painful pustule on the inner canthus of this eye. The ulcer was cauterized with acid nitrate of mercury, and in three weeks it was cicatrized. Later there was swelling of the cervical glands and development of syphilitic cachexia, and for more than a year he was under treatment.

Another case is given of a woman, 56 years old, who presented herself with a binocular iritis, with a papular eruption of the face. On the upper lid was a firm, resistant, and indolent swelling, and beneath it a small and incompletely cicatrized ulcer. The patient admitted that five weeks before there had appeared a small pimple on the upper lid,—eight days later the tumor. Fifteen days later still came the affection of the sight. The patient's husband was examined, and found to have a chancre of the lip and others in the mouth. The writer goes on to say that a remarkable fact in favor of the unity of the virus of chancres was that the husband, who had chancres on the mouth and on the lip, showed no trace of syphilitic affection.—*La Presse Médicale Belge*, 4 Août, 1878, p. 257.

**Syphilis of the conjunctiva.**—BULL reports a case of chancre of the conjunctiva. Patient, a man of 29, had, on the conjunctival surface of the lower lid, an ulcerated surface with hard base. There was swelling of the pre-auricular gland of the same side. The ulcer was cauterized, and the usual anti-syphilitic treatment commenced. The ulcer healed in three weeks, and after nine weeks there came a roseola. Some weeks later there were mucous patches in the mouth.

The author describes also in the same paper a case of gummy tumor of the sclera of both eyes and pericorneal gummy infiltration of the conjunctiva. The patient was under observation and treatment for a month, when he died of pneumonia. The scleral growths and the conjunctival gummy infiltration both disappeared under anti-syphilitic treatment a fortnight before the patient died.—*Amer. Jour. Med. Sci.*, Oct. 1878, p. 405.

**Gummatous tumor of the ocular conjunctiva.**—The title of BERGER'S case seems to be a misnomer. He describes a subconjunctival or scleral nodule grayish white at the margin of the cornea, 3 mm. broad and 2 mm. high in its centre, associated with an iritis and two condylomata in the iris. The patient had a squamous syphilide over the forehead, temples, and eyelids. Within six weeks condylomata, gumma, and cutaneous syphilide had, under mercurial treatment, disappeared. The favorable issue of this case is perhaps its most interesting feature.—*Aerztlicher Intelligenzbl.*, No. 17, 1878; *Chicago Med. Jour. and Exam.*, June, 1878, p. 636.

**Primary syphilitic ulcer of the eyelid.**—LUBINSKY reports an apparently well-authenticated case of primary syphilitic lesion

of the eyelid. The ulcer involved two-thirds of the upper lid. Twenty-seven days after the patient had been received in the hospital, and when the ulcer had nearly healed and showed a marked induration, there was a swelling of the pre- and post-auricular glands of the same side. On the thirty-seventh day a characteristic roseola syphilitica was observed on the breast, and glandular enlargements in various parts of the body.—*Klinisch. Monatsbl. für Augenheilk.*, April, 1878, p. 166.

**Syphilitic tarsitis.**—FUCHS reports three cases of tarsitis syphilitica. The characteristic symptoms which these cases illustrate were marked swelling of the lid or lids, which swelling is plainly in the tarsal cartilage, and is painless. An incision made into this shows a grayish-white, bloodless tissue. The other tissues of the lid are only slightly and secondarily involved. The affection comes on slowly and painlessly advances to its height, and then as slowly recedes. The prognosis is favorable.—*Klinisch. Monatsbl. für Augenheilk.*, Jan. 1878, p. 21.

**Syphilitic tarsitis.**—BULL describes a case of gummy infiltration of the tarsus of the lower eyelid. The lid was very much swollen, hard, resisting, solid to the touch, and painless. The patient had contracted syphilis four years before, and had at the time of the present affection a pustular eruption on the face and neck. The mercurial inunction and use of large, increasing doses of iodide of potash was administered, and at the end of six weeks the tumor had entirely disappeared.—*New York Medical Journal*, Sept. 1878, p. 272.

**Syphilitic amaurosis.**—QUAGLINO reports a case of atrophy of the optic disks with paralysis of the third, fourth, and sixth cerebral nerves. There had been double optic neuritis, and probably gumma at the base of the brain. There was intense headache, vertigo, and vomiting. Mercurials, both by subcutaneous injection and by inunction, were used until salivation was induced. The paralysis of the ocular muscles and the blindness (the patient was able to recognize day from night only with one eye) not being at all relieved, Quaglino administered decoctum Pollini (a proprietary anti-syphilitic mixture, the constituents of which are not generally known), with the effect of stopping the headache, vertigo, vomiting, and of improving the vision so far that the patient could go about alone, recognize persons, and see the hands on a watch. The author pays a high tribute to the nostrum, higher than this happy issue of a single case would seem to justify.—*Giornale Ital. delle Mal. Ven. e della Pelle*, Agosto, 1878, p. 215.

**Syphilitic paralysis.**—ALEXANDER considers the monocular paralysis of accommodation and mydriasis, occurring in syphilitic subjects, one of the latest manifestations of the disease and dependent on brain lesion.—*Berlin. Klin. Wochensch.*, 1878, No. 21; *Klin. Monatsbl. f. Augenheilk.*, July, 1878, p. 334.

**Decoctum Pollini in syphilitic eye diseases.**—Three cases from the Ophthalmic Institute in Milan are described, in all of which the ocular trouble depended on grave syphilitic disease. In all of these cases the decoctum Pollini was used after little or negative results from the use of mercury and potassium.

The first case was one of choroiditis, occurring in a patient with papular syphilide and ulcerations of palate and fauces. Under the use of the decoctum an improvement of the ophthalmoscopic appearances was noted and the vision improved, although to what extent does not appear, as no accurate measurements of the vision are published.

The second case was one of specific retinitis. The patient recovered from his ocular trouble, and, after taking twenty-four bottles of the decoctum, left the hospital.

The third case was one of acute iritis. On the 12th of December patient entered the hospital. She received iodide of potash internally,—inunctions. Locally, for the eye, atropine and vaporized calomel. In spite of all, the iritis grew worse, and the Pollinian cure was instituted on the 23d December, omitting all other remedies save the atropine. In a month patient left the clinique, and a month later she was cured. To one familiar with the course of a specific iritis, the impropriety of inferring that the decoctum of necessity relieved this patient is evident. This form of iritis slowly, under the most fortunate treatment, advances to its acme, and as slowly recedes. For purposes of a comparative study of the two forms of treatment, the length of time allotted to the first was much too short. All of these cases to which we have referred lack careful statement and recorded vision to make them of scientific value.—*Giornale Ital. delle Mal. Ven. e della Pelle*, Febbrajo, 1878, p. 15.

## REVIEWS AND BOOK NOTICES.

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*Epitome of Skin Diseases.* By Tilbury Fox, F.R.C.P., and T. C. Fox, M.B., B.A Second American edition. Philadelphia: Henry C. Lea, 1879, pp. 216.

The great activity of the age, together with the immense developments in various branches of medicine, has given rise to a demand (whether healthy or not) for condensed presentations of the special departments into which the healing art has expanded, and the book before us represents an attempt to present the subject of dermatology in a concise manner for the use of those who cannot or will not enter it more deeply.

The Drs. Fox have certainly fulfilled their work well, and have compressed a very considerable amount of information into this little work, and possibly it may serve a good purpose in showing to the neophyte how much there is to learn, and how little he already knows of this branch. The danger is, however, that the "busy practitioner" (who generally is such in name rather than actual fact, for the real busy men study the most), the danger is that he will take such a work as this and use it as a work of reference, simply because it is very brief, alphabetically arranged, and contains a large number of prescriptions, which latter he can (and will) launch out against the diseases which he supposes that he has, without any adequate knowledge of their real nature and relations. We cannot help the conviction that the world would really be better off without the vast number of "compends," "epitomes," "manuals," "pocket series," etc., by which it is attempted to make a "royal road to learning" by means of their purchase.

As a convenient reference to recent opinions of the authors, and as giving some valuable hints in regard to treatment to those already well acquainted with dermatology, we are very glad to welcome the work, but for those who desire to possess within a single cover a book which will enable those unfamiliar with skin diseases to recognize and treat them successfully, we cannot recommend it, for the simple reason that the subject cannot be compressed into a work of this size, even by the accomplished authors of this one.

There are many points which we would like to pass under notice, but space forbids. This second American edition has been prepared with a special view to the American market by the insertion of a short statement of the "Peculiarities of Skin Diseases in the United States," consisting of the conclusions from Dr. White's address on this

subject before the International Medical Congress of Philadelphia in 1876; and also by the introduction of the scheme of classification and nomenclature of diseases of the skin adopted by the American Dermatological Association at its last meeting.

The introduction of this latter we consider to be peculiarly unfortunate, both for the reader, for the dermatological world at large, and for the honor of American dermatology. This scheme was adopted only provisionally, and must be the subject of very great changes upon further study, for reasons which have been already pointed out in this issue,\* so that it is particularly ill advised to have it thus perpetuated in its present state.

*Clinical Treatise on the Diagnosis and Treatment of Diseases of the Skin (Klinisk Veiledning til Diagnose og Behandling af Hudens Sygdomme).* By Dr. S. Engelsted, Physician-in-chief of the General Hospital, and Clinical Teacher in the University. Copenhagen: C. A. Reitzel, 1879, pp. 394.

Dr. Engelsted is personally known to many in this country from having taken part in the International Medical Congress in Philadelphia in 1876, at which he presented an excellent paper upon the "Measures adopted in Denmark to prevent the Spread of Venereal Disease;" he also participated generally in the discussions in the Section on Dermatology and Syphilography. For many years he has had charge of the Skin and Venereal Department of the General Hospital of Copenhagen, and the present treatise, together with one on venereal diseases which appeared in 1877, is, as it were, a report of the work done there; that is, it is a clinical presentation of the entire subject, illustrated by cases.

A very satisfactory element in the work is the adoption of a nomenclature and classification which renders it of very considerable interest to dermatologists in general, as it enables one to recognize with certainty diseases of the skin as observed in Denmark, and affords a key to other Danish dermatological literature. The nomenclature referred to is that based on the Greek and Latin, and in explanation of the work, Dr. Engelsted, in the preface, speaks as follows: "As to the order of the material, I have tried to follow a plan proposed by Dr. Duncan Bulkley, of New York, which seems to give a better summary of the subject than most other systems with which I am acquainted." By this means the student in Denmark is taught to recognize the same disease in other countries and in text-books and journals in other languages, and by means of the Danish synonyms given, uniformity and certainty can be attained by those outside who may desire either to observe affections of the skin there or to refer to writings on the subject.

In looking at the statistics given of fourteen years, one is struck with the enormous number of cases of scabies which appear in the earlier years and with the comparatively small number occurring later. Thus, in 1865 scabies formed nearly 75 per cent. (!) of all the cases,

\* Page 136.

whereas in 1876 and 1877 it formed but 20 per cent. of the whole. He states that almost the same diminution in the proportion of scabies to other skin diseases was observed by Dr. Bergh, in the civil hospital in Copenhagen, during the same interval of time, which certainly speaks very well for the medical efforts at its extinction. Another very striking peculiarity is the small ratio which the vegetable parasitic diseases bear to the total cases, the highest being 2.4 per cent., against 4.8 per cent. as observed in New York City. Eczema forms there, as here, about 30 per cent. of all cases, in years where the proportion of scabies cases did not by their great numbers disturb all ratios.

The plan of the work is somewhat new, namely, to make fully-detailed clinical histories stand frequently in place of descriptions. Like so many foreign works, this book has no index.

*Report of Cases of Diseases of the Skin and Syphilis treated at the Clinic and Dispensary of the University of Rome. (Raccolta di Casi Clinici delle Malattie della Pelle, etc.)* By Dr. Casimero Manassei. Roma, 1876.

This work consists of a series of 36 photographs, plain and colored, of diseases of the skin, with 76 pages of descriptive letter-press. As a contribution to the general diffusion of knowledge in regard to affections of the skin as observed in various countries, this, as also the report of the Palermo clinic, by Profeta, with its 22 photographs (reviewed in ARCHIVES, vol. iv., p. 276), is of real value, but outside of Italy the works will, of course, have but little practical utility for the general physician or specialist.

A step in advance has been taken by Manassei over Profeta, in employing exclusively Latin names and designations for all the cases, and the metric system of weights and measures in all prescriptions, thus resting the scientific work of Italy on a basis which the science of all civilized nations can recognize: this adhering, as is often largely done here, to Latin names which are well recognized, and the absence of innovations, cannot be too highly commended, for where the terms or qualitatives belonging to the languages of each country are introduced into scientific work only the greatest confusion must result, as has been sadly the case in dermatology. It is indeed interesting to look over 36 photographs, taken in a distant country, with another language, and find that they correspond almost exactly with the same diseases as observed here, and that they are called by the same names, in a language common to science the world over. If such methods are pursued by dermatologists in all sections of the world, this branch of medicine will soon lose the opprobrium of obscurity and confusion attached to it, and the pathology and treatment of diseases of the skin, as well as their diagnosis, will rest on grounds as solid and clear as those possessed by any class of diseases.

In regard to the photographs composing this collection, they, as also those of Profeta before referred to, are unusually good pictures, really artistic productions; but as far as the attempts at

coloration go, they are a failure. A striking example of this is shown in the case of psoriasis, where the colored picture gives almost an erroneous idea of the lesion, while the plain photograph following portrays the affection most perfectly. The macular syphiloderm also is made to appear very falsely in the colored picture. Of particular interest are the three photographs taken from an undoubted and a very severe case of lichen ruber exudativus, in a boy of 8 years. Six pages are given to discussion of the case, and the author differentiates the disease from those with which it might be confounded; the curved and greatly hypertrophied nails are well shown in the pictures.

The text consists generally of two pages to each photograph, giving a short clinical history of the case exhibited, the treatment employed, and a few more general remarks appended to each, in regard to points of interest in pathology or treatment. If such collections of photographs could be given out from more clinics, observers would understand each other much better, and more certainty would be introduced into the science and practice of dermatology.

*Atlas of Skin Diseases.* By Louis A. Duhring, M.D., Professor of Skin Diseases in the Hospital of the University of Pennsylvania, etc. Part V. Philadelphia, 1879: J. B. Lippincott & Co.

The four diseases represented in this part, namely, scabies, herpes zoster, tinea sycosis, and eczema (vesiculosum), are affections which are continually presenting themselves for treatment to every medical practitioner, and are such as at times present very considerable difficulties in diagnosis. To say that they are excellently portrayed in the section of the Atlas before us is not enough; the plates, if possible, excel those which have preceded, and more than justify the high anticipations of those who have watched the appearance of this Atlas from the beginning.

In the excellent plate on scabies the author has attempted to give the cuniculi or insect furrows belonging to the disease. They are, in our judgment, too black and too well defined to answer to those commonly observed clinically, and there is rather too much of the dotted appearance to them.

The plate of zoster can hardly be criticised, except that in many cases the vesicles appear more in separate clusters, are often of more varied sizes than occurred in this case, and generally present rather more flattening than is shown in the picture.

The representation of tinea barbæ (parasitic sycosis) is not only a beautiful piece of art, but exhibits very clearly the features of the disease. A comparison with the picture of non-parasitic sycosis, given in Part II., shows the striking clinical differences between the two admirably.

Probably the most difficult plate to produce was that of acute eczema, and, in our estimation, it is one of the best which has appeared in any atlas, although in certain places where there should apparently be moisture the coloring fails to represent it.

The letter-press is in Dr. Duhring's clear and concise style, and the directions for the recognition and treatment of each disease leave little to desire.

*Hereditary Syphilis Studied in its Clinical, Hygienic, and Medico-Legal Relations. (La Sifilide ereditaria studiata in Relazione alla Clinica, all'Igiene ed alla Medicina Legale.)* By Dott. Primo Ferrari, Prof. in the Univ. di Perugia. Pisa, 1877.

Ferrari's scholarly treatise (which cannot be properly reviewed in this connection) is remarkably satisfactory in dealing with a number of questions which are too often neglected in studies of this sort. After discussing in course the pathological anatomy, symptomatology, diagnosis, termination, prognosis, and treatment of the disease, the author considers the following subjects: alimentation, hygiene, and therapeutic treatment requisite after specific medication; the relations of hereditary syphilis to scrofula and rickets; public hygiene; the relations of the nurse and child; syphilis and vaccination, and syphilis and matrimony. In the full bibliography we find the names of a few American authors, among them those of Bumstead, Taylor, and Keyes.

J. N. H.

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## BOOKS AND PAMPHLETS RECEIVED.

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*Pathologie und Therapie der Hautkrankheiten in Vorlesungen für Prakt. Aerzte und Studirente.* By Moriz Kaposi. Erste Hälfte. Urban & Schwarzenberg, Wien, 1879.

*Beretning fra Almindelig Hospitals, 2den Afdeling for 1877.* By Dr. R. Bergh, Copenhagen, 1878.

*Bericht der II. Klinik und Abtheilung für Syphilis des Wiener k. k. Allgemeinen Krankenhauses für das Jahr 1877.* By Prof. Zeissl, Wien, 1878.

*Annual Report of the Pennsylvania Free Dispensary for Skin Diseases, from November 1, 1877, to October 31, 1878.*

*Case of an Undescribed Form of Atrophy of the Hair of the Beard.* By Louis A. Duhring, M.D.

*A Case of the so-called Xeroderma (or Parchment Skin) of Hebra.* By Louis A. Duhring, M.D.

*The Botanical Relations of Trichophyton Tonsurans.* By I. Edmondson Atkinson, M.D.

*Ringworm in Public Institutions. Rosacea.* By John V. Shoemaker, A.M., M.D.

*On Permanent Removal of Hair by Electrolysis.* By George Henry Fox, A.M., M.D.

*A Clinical Lecture on Anesthetic Leprosy.* By J. Nevins Hyde.

*The Use of Calcium Sulphide in the Treatment of Inflammations of the External Auditory Meatus.* By Samuel Sexton, M.D.

*Notes on Molluscum Sebaceum.* By Walter G. Smith, M.D., F.K.Q.C.P.I.

*Two Cases of Psoriasis,—the one Treated by Prolonged Daily Immersions, the other by an Ointment of Chrysophanic Acid.* By Balmanno Squire, M.B.

*Illustrations of a Novel and Successful Treatment of Psoriasis.* By James Adams, M.D., L.R.C.S.E., etc.

*A Case of Lupus of the Face Treated by Linear Scarification, aided by Erosion.* By Balmanno Squire, M.B.

*Two Cases of Severe Iodide of Potassium Eruption.* By Tilbury Fox, M.D.

*Cases of Follicular Mal-nutrition (Cacotrophia Folliculorum).* By Tilbury Fox, M.D.

*Histology of Dysidrosis.* By Tilbury Fox, M.D., and H. Radcliffe Crocker, M.D.

*On the Condition of the Skin in Tinea Tonsurans.* By George Thin, M.D.

*Case of Epithelioma of the Lip in a Woman.* By George Thin, M.D.  
*On the Proportion of Red Corpuscles in the Blood in some Skin Diseases.* By George Thin, M.D.

*On the Removal by Operation of a Hairy Mole Occupying Half the Forehead.* By W. Morrant Baker, F.R.C.S.

*On a Case of Addison's Disease Improving under Treatment, and on the Relationship between Addison's Disease, Vitiligo, and Alopecia Areata.* By Dr. M'Call Anderson.

*Contribution à l'Étude des Amblyopies symptomatiques de la Syphilose cérébrale.* By Charles Mauric.

*Cases Illustrating Two Rare Diseases of the Eyelids. Syphilitic Gummata of the Conjunctiva.* By Charles Stedman Bull, M.D.

*Syphilitic Affections of the Ear.* By Albert H. Buck, M.D.

*A Clinical Lecture on Inflammatory and on Spasmodic Stricture of the Uretha.* By H. B. Sands, M.D.

*Eine Verbesserte Behandlung der Epididymitis.* By Prof. Zeissl.

*On the Treatment of Strictures of the Fossa Navicularis.* By Henry G. Piffard, M.D.

*On Aspermatozi og Aspermatesine.* By Dr. R. Bergh.

*Report of Two Thousand Cases of Disease in Children Treated at the Demilt Dispensary, New York.* By Brynberg Porter, M.A., M.D.

*Apparatus for Transfusion. Asphyxia in New-Born Children Considered from a Medical and a Legal Stand-point.* By H. J. Garrigues, M.D.

*A New Method of Removing Interstitial and Submucous Fibroids of the Uterus.* By T. Gaillard Thomas, M.D.

*A Case of Acute Puerperal Inversion of the Uterus.* By John Byrne, M.D., M.R.C.S.

*Anæsthesia in Parturition.* By A. H. Halbertstadt, A.M., M.D.

*Laceration of the Cervix Uteri.* By William Goodell, A.M., M.D.

*The Relations of the Conducting Mechanism of the Ear to Abnormal Hearing.* By Samuel Sexton, M.D.

*Complete Occlusion of the External Auditory Canal by a Dermoid Membrane an Evidence of Horizontal Motion Outward in the Epidermis of the Canal.* By Albert H. Buck, M.D.

*Ophthalmia Neonatorum.* By Richard H. Lewis, M.D.

*Contributions to Ophthalmology.* By Dr. C. R. Agnew and Dr. D. Webster.

*Trichiasis and Distichiasis: Reflections upon their Nature and Pathology, with a Radical Method of Treatment.* By Charles E. Michel, M.D.

*Feigned Insanity, Homicide, Suicide. Case of William Barr, alias Ball.* By Carlos F. MacDonald, M.D.

*Are Inebriates Automatons?* By George M. Beard, M.D.

*The Nature and Treatment of Inebriety; also, the Opium Habit and its Treatment.* By Edward C. Mann, M.D.

*Galvanism in the Treatment of Sciatica.* By V. P. Gibney, M.D.

*The Nature and Diagnosis of Neurasthenia.* By George M. Beard, M.D.

*The Brazilian Tea, or Clea-Maté.* By Charles Wm. Zaremba, M.D.

*Opium as a Tonic and Alterative; and its Hypodermic Use in the Debility and Amaurosis sometimes consequent upon Onanism.* By B. A. Pope, M.D.

*Note on Hydrobromic Acid.* By Edward R. Squibb, M.D.

*Diseased Germs: their Origin, Nature, and Relation to Wounds.* By B. A. Watson, M.D.

*A Therapeutical Inquiry into Rational Medicine.* By S. Wetmore, M.D.

*The Constituents of Climate, with Special Reference to the Climate of Florida.* By Frederick D. Lente, A.M., M.D.

*Case of Sarcoma of the Kidneys in a Negro Child.* By W. H. Geddings, M.D.

*On the Treatment of Chronic Catarrh of the Bladder, and of some Forms of Acute Cystitis.* By Theodore Deecke, M.D.

## MISCELLANY.

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**Dermatology in Chicago.**—Dr. James Nevins Hyde, our excellent collaborator, has been made professor of dermatology and venereal diseases in the Rush Medical College of Chicago. This chair is now for the first time established in the regular course of this college.

**Mr. Wilson's professorship.**—We were sorry to learn from Mr. Wilson himself that probably the professorship of skin diseases which he founded and endowed in the Royal College of Surgeons of England will cease with the present year, he having resigned it, and that the funds are probably to be diverted to a chair of pathology. Not that the latter topic is of the less interest, but no branch of medicine has thus far received so little support from the colleges and societies as dermatology, and yet in no branch of medicine is the general profession confessedly less posted than in this very department.

**Dr. A. R. Robinson,** who has been associated with the ARCHIVES as collaborator almost from its beginning, has recently been appointed physician to the skin department, Demilt Dispensary (New York), to serve in the place of Dr. Robert Campbell, who has resigned from press of other duties. Dr. Robinson is already very favorably known in the dermatological world by his histological researches on pompholix, sycoisis, and psoriasis, and his enlarged field of observation will, it is hoped, yield yet greater results.

**Death of Bazin.**—This well-known French writer and teacher of dermatology died about three months since. He had been retired two or three years ago from active duty at the Hôpital St. Louis on arriving at the age of seventy years, when such connection ceases by law. Probably no one name stands out more prominently in connection with French dermatology than does that of M. Bazin, but his publications were so wordy and diffuse that they have never ranked high, and his real influence on dermatology cannot compare with that of many others in the present or past generation. As a personal teacher he was attractive, affable, and ready to demonstrate to students, but exceedingly set in his opinions and dictatorial in asserting them.

**Death of Hermal Beigel.**—Although perhaps better known as a gynæcologist, Dr. Beigel made several interesting and im-

portant contributions to dermatology, and wrote a popular treatise on "The Human Hair," published in London in 1869. He was the first to describe, in 1855, under the title "Ueber Aufreibung und Bersten der Haares," the curious alteration of the hair-shaft now called trichorexis nodosa. He was a German, and died in Vienna, January 8, 1879.

**Dr. Thomas A. Brown**, of Baltimore, professor of surgery in the College of Physicians and Surgeons, and president of the Baltimore Medical and Surgical Society, who has made several contributions to the ARCHIVES OF DERMATOLOGY is reported to have died on January 27, 1879. Dr. Brown, though practising surgery, was much interested in syphilis and venereal diseases, and was one of those who met at Philadelphia, September 6, 1876, to organize the American Dermatological Association.

**American Dermatological Association.**—The Transactions of the Second Annual Meeting of this association have been reprinted from the *New York Medical Journal*, in a pamphlet of sixty-three pages. As the proceedings were given in full in the October issue of the ARCHIVES, they need not be commented on further. The present pamphlet contains in addition the Report of the Committee on Statistics, embracing an analysis of nearly seventeen thousand consecutive cases of skin disease in special, private and dispensary practice in Boston, New York, Philadelphia, Baltimore, St. Louis, and Chicago. In a part of this report there are interesting data given in regard to the presence of leprosy in America. The next meeting of the Association will be held at New York on August 26, 27, and 28, 1829.

**A new professorship of dermatology and syphilis in Paris.**—The present Minister of Public Instruction in France, M. Bardoux, who is on very friendly terms with the medical profession, and desirous of promoting its interests in every possible way, has promised to create another new chair of dermatology and syphilis, which will probably be given to Dr. Fournier.

**Mr. J. Hutchinson, F.R.C.S.**, who has succeeded Mr. Spencer Wells as lecturer in the Royal College of Surgeons, proposes to discuss "certain diseases of the eye, skin, and joints, which are produced through the influence of the nervous system." Mr. Hutchinson has been elected President of the Pathological Society of London for the year 1879.

# ARCHIVES OF DERMATOLOGY.

JULY, 1879.

## ORIGINAL COMMUNICATIONS.

### A NOTE UPON THE "CRISOGENIC" SIGNIFICANCE OF CERTAIN CUTANEOUS ERUPTIONS IN NERVOUS DISEASE.

BY ALLAN McLANE HAMILTON, M.D., NEW YORK.

THE nervous origin of many skin diseases has been so extensively studied and so well described during the past four or five years, that there is now little doubt as to the nature and causation of such affections as herpes, pemphigus, and urticaria. These eruptions have an importance of another kind, however, which I think has never been fully realized, and this arises from their symptomatic connection with certain crises in the course of established nervous disease.

I have been prompted to present a few brief notes of two or three cases which illustrate the cutaneous expression of central nervous states.

Mr. B., a delicate, overworked young man, presented a well-marked history of nervous exhaustion, the pathological state being, probably, an anæmia of the spinal cord. He was troubled by excessive weariness, incapacity for work, tingling in the soles of his feet, pain over the seventh cervical spine, weak digestion accompanied by flatulence, and dysæsthesia of various kinds. His condition had lasted for several years, and was greatly aggravated by elevation of temperature and immoderate exercise. Over his shoulders and back there was a plentiful crop of acne, but at no other part of the body was this found. Under the influence of strychnia, the galvanic current, and salt baths, his general condition improved to a decided extent, and an immediate amelioration took place in the eruption of acne, the spots disappearing within a few days. He seemed brighter and better, but in his improved condition he committed indiscretions in diet, and spent an evening drinking rather freely with some friends. A few days afterwards he consulted me,

his symptoms having returned. I found his back again covered with acne, which disappeared as he again improved. This feature of his disease varied according to his condition of general health, usually preceding a relapse; and while he was under my care (during a period of several years) I was enabled to notice a certain constancy in the appearance of the skin disease.

In epileptics I have noticed the development of acne or an expression of nervous irritability in patients who had for some reason been for a time free from paroxysms, and in these cases I was led to infer that the acne was an indication of a lesser degree of excitement. In this connection it is hardly necessary to refer to the forms of chronic sexual excitement in which this cutaneous lesion appears. Among boys who masturbate, or boys or girls who are entering puberty, I believe the acne commonly found to be the result of a perverted condition of the nervous system, and in the epileptic cases alluded to there was the element of sexual excitement very strongly presented.

It has been my privilege to observe, as a feature of chorea, in two instances, an associated eczema, and from conversation with professional friends I have learned of other cases. The two children who suffered from chorea were badly nourished and debilitated. In one case—a girl of twelve—there was hemichorea of the left side, while in the second case the movements were general.

In the first child the chorea had begun a month before her visit, and previous to this time she had never had eczema or any eruption, with the exception of an attack of measles at the fifth year. Three weeks before the movements began, she noticed the appearance of eczema upon the left calf and in the popliteal space, and subsequently it appeared on the left side of the neck and face. She had been taken from school and to a dispensary for treatment, but the mother did not know what medicine the child had received. I found her suffering from very active movements, a certain degree of feebleness of the lower extremity, and the eruption before spoken of. Under the use of arsenic in increasing doses and unguentum zinci oxidi benzoici her eczema began to improve, and with it the movements. This treatment, with strychnia, effected a cure in about two months. During the next spring, however, the eczema reappeared, and with it the movements, but under treatment she again recovered. There was no eruption during the interim, none of the chorea whatever, and her health was excellent until towards the end of the winter. In this case, then, the eruption and movements were unilateral, both disappeared under the same treatment, and both reappeared a year later.

In the second case—a boy of six and a half—the movement began in the right side, but involved all four extremities and the face. His eczema appeared upon the head, back of both thighs, and upon the anterior surface of the right arm. It lasted two or three weeks after the subsidence of the choreic movements, which disappeared after a five weeks' course of strychnia, arsenic, and ether spray to

the spine. I have not seen him since, but look with some anxiety and interest to the future.

Though Handfield Jones\* is inclined to disbelieve in disorders of nutrition as a consequence of section of the fifth nerve, cases have been reported in which severe neuralgia, the pressure of tumors, and other causes or results of disordered function have been followed by corneal ulceration. I have myself seen very conspicuous skin lesions in anaesthesia of the fifth nerve, and the case of a lady who has been under my care for some time, suffering from malarial neuralgia of the fifth nerve, presents an unusually interesting symptom which has valuable pathological significance. Her headaches were periodical, and occurred during a long time, at intervals of two weeks, when they would last for eight or ten hours; and though there was no gastric disturbance, they were very frequently followed by a crop of labial herpes, which lasted for a few days. In this case the infra-orbital and dental branches were the seat of great pain. Quinia and arsenic removed the disease.

My note-books contain other cases which are equally suggestive, showing that marked variation in the behavior of nervous diseases is indicated oftentimes by the development of skin troubles of various kinds. In such serious affections as locomotor ataxia and other spinal diseases much remains to be studied, and, doubtless, these peripheral indices of central disturbance may be made use of in diagnosis and treatment. In the cases I have presented the appearance of cutaneous changes certainly bears some relation to the development or modification of the several neuroses, and they at least offer a hint in the matter of therapeutics.

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## DERMATITIS VENENATA; OR, RHUS TOXICODENDRON AND ITS ACTION.†

BY ROSWELL PARK, A.M., M.D.,

Assistant to Chair of Anatomy, Chicago Medical College, Surgeon to South Side Dispensary, etc.

THAT dermatitis venenata is a sufficiently important as well as annoying malady to deserve a special place in dermatological literature will be generally conceded, especially by those who suffer from it. It has been a matter of surprise to the writer that the standard text-books and journals contain so little information upon the subject; for with the exception of a page and a half in Duhring's work, and a masterly article by Dr. White, of Boston, in the *New York Medical Journal* for March, 1873, one can glean but little satisfaction from them.

The genus *Rhus* is an extensive one, having representatives in all

\* Functional Nervous Disorders, p. 751.

† Read before the Chicago Medical Society.

parts of the world. These are for the most part shrubs, or very small trees, with simple or unequally pinnate leaves. *Rhus toxicodendron* and *R. radicans* are known under the common names of poison ivy, poison oak, poison vine, etc. They are among the number of plants or shrubs known to possess peculiarly irritating effects upon the human skin, e.g., the poison sumach or dogwood (*R. vernix*), mezereon, arnica, and others. The poison oak is usually found as a shrub, three feet high or thereabouts, with leaflets angularly indented and pubescent beneath. But this size and character of foliage are not constant; it may attain more the appearance of a vine or trailing plant. The poison ivy is a hardy climbing vine, with small, greenish-white flowers in panicles or compound racemes on the sides of the new shoots. The berries are nearly round, and of a very light green color.

There seems to be some confusion of terms among different writers. Both the vine and the shrub go under the common designation of *R. toxicodendron*; though the former is often described as *R. radicans*, and the latter as *R. venenata*. Perhaps, then, it would be better to discard the common term and thus designate them, reserving for the sumach the term *R. vernix*.

The poison ivy bears many resemblances to our common woodbine, or Virginia creeper. The easiest way to distinguish them is to remember that the former has but *three* leaflets, which grow on long, semicylindrical petioles, while the latter has *five*. I have more than once taught children to remember that a vine which has a leaf for the thumb and each finger of one hand is safe for them to handle; otherwise they should avoid it.

These plants abound in Canada and the northern part of the United States. The poison oak was described in 1635 by Cornutus as a species of ivy, in his work on plants in Canada. It was known to the Indians both as a poison and as a medicinal agent; the effects of emanations from it were mentioned by Kalm and other travellers in North America. In 1788 a French physician, Du Fresnoy, began experimenting with it,—using it in some obstinate cutaneous affections, as well as in paralysis. Some years later, Dr. Horsfield found that it possessed acro-narcotic powers. It is put in the secondary list of the United States Pharmacopoeia, and a tincture is officinal among the Germans. Without stopping to consider its effects, some of which are well marked when exhibited internally, it will suffice our present purpose to remark that two deaths have been recorded from ingestion; in one case of the berries, in the other of an infusion of the root.

The *R. radicans* emits when wounded a yellowish, milky juice, which assumes a permanent black color on exposure to the air, and leaves an indelible stain upon cloth which resists the action of many chemicals. This quality of the juice is probably attributable to a peculiar principle existing in almost all vegetables which possess the power of poisoning by contact or emanation, since it is found in the “deadly upas,” the manchineel, the Cashew apple, etc. (“Griffith’s

Med. Botany"). From the juice of *R. vernix*, and other species growing in Japan, is made the beautiful black lacquer of the Japanese. They select a fine-grained wood for their lacquered-work, and apply several coats, grinding down and polishing each one before another is laid on.

With regard to the nature of the poison, there can be no doubt now that it is owing to a volatile acid to which has been given the name of *toxicodendric acid*. It has strongly acid reactions, completely neutralizes bases, forms with excess of oxide of lead a soluble salt, precipitates with soluble salts of lead an insoluble toxicodendrate, and separates metallic gold from a warm solution of its chloride. Potassium permanganate is readily reduced by it (Stillé). It resembles formic and acetic acids in many of its reactions, but does not produce a red color with neutral ferric salts. It was first investigated by Dr. Khittel in 1857 (*vid. Amer. Journ. of Pharm.*, 1858), and was more thoroughly examined by Prof. Maisch (*Proceedings of Amer. Pharm. Association*, 1865).

This volatile acid, then, is the active, if not the only, constituent of the emanations from the plant. That different individuals should vary so greatly in susceptibility to its action may cause surprise, but should never obscure our diagnosis. The fact that several individuals have been exposed, and only one or two affected, should never perplex us, but rather the reverse.

Dr. White reports, on hearsay evidence, that one person had been poisoned by the presence of imported lacquered ware in his apartments. Prof. Maisch relates that he was somewhat affected while experimenting with the acid, and that several persons entering his laboratory were more or less poisoned. Dr. Bigelow states that he has known persons to be poisoned in winter while the wood of *R. venenata* was burned upon the fire ("Med. Botany"). Dr. White also relates three cases where the sufferers had simply handled chopping-wood, and one case of a young lady who had simply handled foliage for Christmas decoration.

I have had occasion to treat within a month a laborer thus affected, who for some days had done nothing but load grain at one of our warehouses.

I have also been told, by good authority, of a homœopathic physician in Ohio who cannot dispense or prepare his own dilutions or preparations of *rhus tox.* without suffering subsequently. In my own case I have more than once been a victim when I was not conscious of having handled, touched, or even approached a poison ivy vine.

Just here a question of some interest arises. Does the season of the year exercise any influence on the virulence of the poison? The cases just related, and many other experiences, seem to prove that it is sufficiently active at all times. The fact that the practitioner treats most of his cases in the summer and autumn may be accounted for by the fact that the woods and fields are most attractive at those seasons, and consequently more visited, while the

gorgeous changes of foliage through which the leaves of the poison ivy pass make it especially sought after by, and attractive to, the unwaried.

The lower animals seem, at times, liable to its effects. Dr. White learned of a hunting-dog which had more than once been affected; and he refers to statements that insects never attack the Japanese species.

Dr. Bigelow quotes an account of a swarm of bees alighting on the branches of *Rhus venenata*. The next day they were found dead, and their bodies were black and swollen. On the other hand, the leaves of both species are eaten by worms, and in spring the flowers are sought by numerous insects.

Is the malady contagious? While it is probable that contact with the skin of others immediately after handling the vine, and before ablution of the hands, might be an exciting cause, I have been unable to satisfy myself that the affection may be considered contagious. But I do incline to the opinion that it is *auto-inoculable*, if I may transplant this phrase, being spread by contact of the different parts of the same individual.

**Symptoms.**—The “period of incubation” varies from a few hours to a few days after exposure. Generally thirty-six to forty-eight hours elapse before the patient experiences any annoyance. If the patient be a weak and fretful child, there may be some febrile symptoms and nervous disturbance at the outset. Otherwise the first symptoms are burning heat and itching in different spots, usually the face and hands, as these are the most exposed parts. At this time the surface which is the seat of these sensations has a reddened appearance, in some cases with livid spots, and soon after, the cellular tissue in the vicinity becomes oedematous. About this time, or a little later, the first characteristic vesicles begin to appear, also first on the face and hands, and I have usually noticed them first of all between the fingers, unless the patient were a laborer with tough skin, in which case they appeared on the face.

The next locality involved, in males especially, is usually that of the genitals, while from here the symptoms may spread irregularly all over the body, or they may remain confined to the parts first attacked.

When the disease is at its height the appearances are about as follows: the surfaces involved are of a lurid red color, more or less oedematous, occupied by patches of papules and vesicles,—these latter often confluent,—with frequent excoriations, from which exudes freely a serous fluid which, drying, forms soft crusts, and which, like the exudation in eczema, has the peculiar property of stiffening cloth. The eyes are often closed from swelling of the eyelids, while the nose, lips, and ears are swelled and drip with serum. The genitals are often enormously tumefied; and in the most aggravated cases there may be so excessive general oedema that the patient will be rendered actually helpless. With all this cutaneous disturbance there is usually some slight febrile reaction, the

tongue may be furred, the action of the alimentary canal somewhat deranged, and the bowels constipated.

The subjective sensations complained of are principally the general malaise and marked irritability and susceptibility of the skin, and the intolerable itching, accompanied or at times intensified by a peculiar stinging, burning heat, which, in some nervous patients, may amount to positive torture. Rest, except by artificial means, is impossible, and the patient is a pitiable object. Of course I have described a severe case, but the picture is not one whit over-drawn. Cases will be met with of varying degrees of severity, from one of trifling consequence to possibly one which may terminate fatally. Dr. Thacher has reported a case where there was loss of hair and nails, and Dr. White (*loc. cit.*) gives account of a fatal case.

The symptoms remain at their height for four or five days, and, in most cases, in seven or eight days from their inception the acute symptoms have all subsided. They may, however, persist longer. One need not be surprised to see an occasional vesicle for a week or two afterward, but this is a trivial matter. Relief is commonly quite speedy, even when no treatment is employed, and there follows, in cases that have been at all severe, desquamation of all that portion of the cuticle that was the seat of the lesions, at least this has occurred in all the cases that have come under my observation. Attention has not been called to this feature in any reports of cases or remarks on the subject which I have seen. Possibly it may have been owing to the energy of the measures instituted to relieve the local symptoms. As to this I have not quite decided.

**Differential diagnosis.**—Are we liable to mistake the trouble? The principal point is to distinguish a specific from a non-specific vesicular eruption (*vide infra*), or dermatitis venenata from eczema vesiculosum. In the former it is usually first seen along the edges or lateral surfaces of the fingers, and where the skin is most thin, and last of all where the skin is thickest, as upon the palmar surfaces. In the latter locality the epidermis is so thick that the vesicles are at first felt rather than seen, having a "shotty" feeling under the fingers. The eruption is more irregular in distribution than that of eczema vesiculosum, while the annoyance, as a rule, is greater. The eruption also is more strikingly vesicular, and the vesicles seem to be born such without passing through an intermediate papular stage. (White.) The skin also returns to its natural state without any marked alteration in the character of the eruption.

The history may assist us in making a diagnosis in many cases. Then, too, it will usually be found that individual features are a guide to a certain extent. Individuals vary immensely in their susceptibility, some enjoying perfect immunity. These latter are usually of dark complexion, dark hair, and spare habit, while the light complexioned, blue eyed, light haired, and those of a "phlegmatic temperament" are perhaps more liable than others.

**Pathology.**—Believing as I do that we have to deal with a *specific eczema*, *i.e.*, an eczema with a specific ætiology, the pathological processes do not vary from those which obtain in the less specific varieties. In the “Dictionnaire de Méd., de Chirurg., et de Pharm.” I find it stated that the contact of the specific poison of rhus determines a violent erysipelatous inflammation of the skin; and a similar statement is made in several of the less recent works. Without denying this statement positively, I can only say that I have never seen nor heard of such a thing. The eruption is essentially vesicular,—as Duhring says, “the eruption is an acute, simple inflammation of the skin, inclining always to spontaneous recovery;” and he then states that the pathological processes are identical with those produced by croton oil. These he describes thus: “The principal site of the disease is the papillary layer. In circumscribed portions of the skin the papillæ are enlarged and infiltrated with cells and a clear fluid. The connective-tissue corpuscles are remarkable for their size and succulence, and are increased in number. . . . This circumscribed inflammation forms the papule of the eczema. A vesicle is formed by the new formation of cells within the papillæ and the superficial cells of the mucous layer swelling up considerably, perhaps rupturing, so that the epithelium is raised.”

In brief, there seems to be a local irritant originating a nervous disorder of the capillary vessels and tissues, a rhythmical contraction and expansion of the capillaries until complete stasis results, then free effusion of fluid and brisk proliferation of the cellular elements, especially in the papillary layer. (Neumann.)

One attack confers no immunity; on the other hand it may render the skin all the more irritable and susceptible. That this may be the case seems more plausible, from the fact that a certain number seem to suffer from other cutaneous affections at indefinite periods after poisoning by ivy. This is not only conceivable, but rational, and has happened in more than one of my own cases. It is also fair to infer that a patient with irritable skin, which reacts promptly to irritation in the digestive tract or elsewhere, should be particularly liable to annoyance from contact with such a pronounced irritant as toxicodendric acid. This certainly seems to me to be the case; the worst cases of ivy poisoning I have seen occurring in just such individuals. Dr. White mentions several cases where the specific inflammation seemed to have predisposed to subsequent cutaneous disease.

**Treatment.**—We now come perhaps to the most important topic for consideration—the treatment. In the first place, I have found it of no small advantage in severe cases to maintain free catharsis, mainly by the saline cathartics or purgatives; keeping the patient at the same time upon a light, non-stimulating, but nourishing diet.

It is not only legitimate practice, also, but humane to ensure rest by chloral, the bromides, or even opiates, giving them *pro re nata* to induce sleep.

The number of remedies recommended for local application is

almost legion. I have found nothing that excels the camphor-chloral mixture (equal parts of each allowed to stand in the open air and liquefy) as a local sedative to relieve the intense itching. It has no specific virtues, however, nor is it astringent nor antiphlogistic,—simply sedative.

The following are some of the numerous drugs recommended as possessing more or less virtue in combating the various symptoms. Theoretically, it would seem as if alkalies were indicated in counter-acting the effect of an acid; hence soda, borax, ammonia, etc., are highly spoken of, and I have found them of some use. If soda be used it should be in strong solutions of the bicarbonate. Soft soap has made an excellent application; and has also been recommended as a prophylactic after handling the ivy. *Per contra*, acids have been used; for instance, vinegar. Dr. Morrison praises very highly a solution of carbolic acid, 2.0, and sulphite of sodium, 12.0, in water, 200.0. (*Phila. Med. Times*, July 3, 1875, p. 629.)

The black wash, *lotio nigra* U.S.P., is very highly spoken of by White and others; and the yellow wash, *lotio flava* U.S.P., is equally recommended on those parts where the epidermis is tougher, as the palms of the hands; while some use a similar wash only made with two or three times the officinal quantity of the corrosive chloride.

Zinc oxide makes an excellent application, used as a dry powder with eight parts of starch, to excoriated parts; while an ointment of the oxide or of calamine is serviceable in the convalescent stage. Dr. Humphrey has tried sponging the surface every hour with one part of zinc sulphate in twenty-four parts of water, and claims that the application is very successful. (*Am. Jour. Med. Sci.*, July, 1874, p. 160.) An alum curd seems to make an excellent application.

Dr. Griffin claims that a saturated solution of potassic chlorate "acts like magic," when applied every three or four hours. (*Med. Brief*, May, 1879.)

Solutions of copper sulphate would seem to be as efficacious as those of the zinc salt, only they should be used weaker. Very cold solutions of sugar of lead are very highly recommended; the salt not only exercising its astringent and sedative effect but permitting the precipitation of the insoluble toxicodendrate of lead.

The use of solutions of ferric chloride and sulphate after the blisters or vesicles have ruptured has been highly praised; and Professor Procter found that Monsel's solution introduced by a pointed instrument into a vesicle while yet it is forming, or after it has formed, either aborts it or dries it up. (*Am. Journ. Pharm.*, 1863, p. 506.)

Bromine in very weak solutions in glycerine or olive oil, one part to fifty, has lately been used with great success. (*N. Y. Med. Record*, April 20, 1878.)

Among vegetable remedies the following, either in infusion, tincture, or fluid extract, and used locally, have high repute: *Verbena urticifolia* (vervain, also used internally), *serpentaria*, *sanguinaria*,

*lobelia*, *Grindelia squarrosa*, *Comptonia asplenifolia* (sweet fern), using the decoction as hot as possible, *gelsemium*, etc. In two rather mild cases I have used equal parts of tinctures of lobelia and sanguinaria, and relieved much of the local annoyance. A decoction of white-oak bark (*Quercus alba*) is very highly spoken of, by Dr. Risk especially. (*Cincinnati Med. Repository.*)

Poultices made of the bruised leaves and stalks of *Lactuca elongata* (wild lettuce) and of horse-weed (*Collinsonia canadensis*) have some repute among the eclectics.

A wash made by boiling the bark of the elder in buttermilk is an old domestic remedy.

Dr. Tydings highly recommends the alcoholic extract of belladonna dissolved in twenty-four parts of alcohol and applied with a feather. (*Maryland Med. Journ.*)

And lastly, Professor J. N. Hyde, of this city, informs me he has never found anything superior to an ointment made by simmering the fresh inner bark of the *Benzoinum odoriferum* (American spice plant) in lard or similar substance, and used externally.

If I here bring this rather formidable list to a close, it is not because I have exhausted a special list of the *Materia Medica*, but because here is already an embarrassment of riches, from which one ought to select a very few remedies upon which experience shall teach him he can rely. Inasmuch as the symptoms are essentially local, we must depend for their abatement chiefly upon local measures; and in proportion to their severity and the clamor of the patient for their relief, we shall usually find ourselves rewarded by his gratitude.

The treatment of the convalescent stage is so simple that I need not address myself to it.

I may be permitted to add that the symptoms of poisoning by the *Rhus vernix* (sumach or dogwood) are very similar to those detailed in this paper, though possibly more severe, while the treatment is in every respect analogous to or identical with that for ivy poisoning.

785 WABASH AVENUE, CHICAGO.

### CASE OF SCLERODERMA.\*

BY FRANK P. FOSTER, M.D., NEW YORK.

APART from the interest always attaching to a case of scleroderma, the following case seems specially worthy of record from its having been considered by several surgeons to be cancer, and from the fact that death took place without the recognized intercurrence of any other disease.

\* Read before the American Dermatological Association, August 27, 1878. For discussion thereon, see ARCHIVES OF DERMATOLOGY, Vol. IV. p. 328.

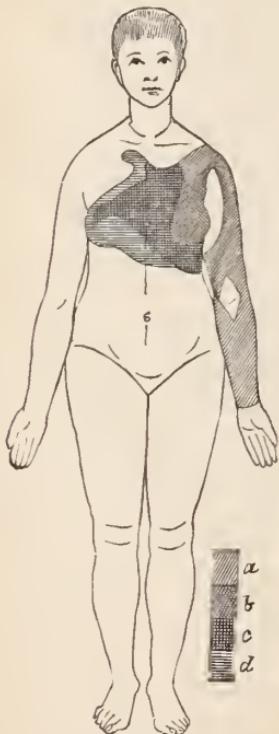
Miss G., of Buffalo, æt. 36, a blonde, of small build, noticed a fissure or abrasion of the left nipple in June, 1875, and about the same time a small swelling under the skin of the breast. Her general health had always been good, and there was no history of cancer in her family. The nipple continued tender for some weeks, occasionally exuding a drop or so of blood whenever it chanced to be injured in any way. She consulted Dr. H. R. Hopkins, of Buffalo, who, in a letter to me dated Feb. 19, 1877, says, "I found the nipple swollen a little and rather sensitive, with an abrasion covering its top. . . . A film would form over it for a day or two, and then come off, leaving a raw surface. At this time the breast was normal in all other respects save a small lump about the size of a chestnut, which seemed imbedded in or attached to the gland at its inner border. . . . I did not see the case again until last August (1876), but understood that during this interval the nipple, and finally the entire breast, had been subjected to various stimulating and irritating applications. At this time the nipple was still symmetrical, but much enlarged, had not regained its epithelium at the top, and had lost it in several places around . . . its base. At one part of the base was a fissure extending quite into the nipple. All of these surfaces had a rather dry look; some pus was secreted, but little, and that not offensive. The breast was larger and warmer than its fellow. The skin and subcutaneous tissues seemed in a condition like the infiltration of chronic inflammation. The . . . gland . . . was firmer than normal, but had nothing of the firmness or feel of scirrhus. The tissues about the breast were normal, and the breast moved easily upon its attachments. . . . From August to October I observed that the whole breast became more firm and less movable, and infiltrations took place into the cellular tissue adjacent, which points, at first doughy, became more firm, with a tendency to involve the overlying skin."

In the autumn of 1876 she came to New York, and consulted two eminent surgeons, who, in consultation, diagnosticated cancer,—the "squirrhe en cuirasse" of Velpeau,—and decided that the case was beyond operative interference.

She applied to me Feb. 8, 1877. At this time the disease affected the whole of the skin of both breasts and that over the sternum and the whole left half of the chest in front, creeping around to the scapula, and the greater portion of the left arm and forearm, as shown in Figs. 1 and 2 (Squire's outlines). The proper substance of the left breast was very much shrunken, and the nipple was somewhat shortened and swollen, and surrounded by a groove of ulceration, discharging a thin, scanty fluid, which was, she said, at times rather offensive. The most decidedly indurated portions of the skin were of a board-like hardness and thinned; the other indurated portions were somewhat swollen. The former were sharply defined, the latter less definite in outline. The condition of the left upper limb varied from day to day, being sometimes very much swollen, with œdema of the hand and a feeling of stiffness in the joints.

She was conscious of some stiffness about the chest-wall, but not of any real crippling of the respiratory movements. Her general health was good and all her functions were regularly performed.

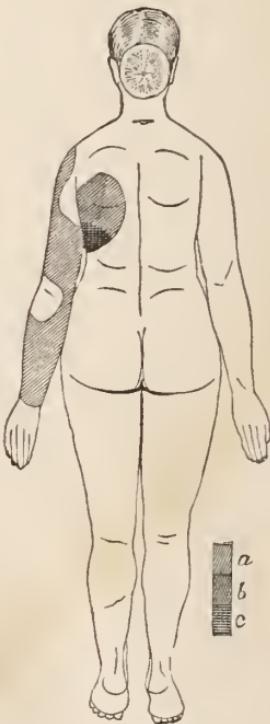
FIG. 1.



*a*, Moderate induration with redness; *b*, excessive induration with redness; *c*, moderate induration without redness; *d*, excessive induration without redness.

Feb. 8, 1877.

FIG. 2.



*a*, Excessive induration with redness; *b*, moderate induration without redness; *c*, excessive induration without redness.

Feb. 8, 1877.

I prescribed tartrate of iron and potassa, and applied galvanism to the affected parts three times a week, using a current from five or six cells only. A medical friend had suggested to her the use of hydrocotyle asiatica, to which I made no objection.

After about ten days, my friend, Dr. E. L. Keyes, saw her with me, and concurred in the diagnosis of scleroderma.

*Feb. 26.*—Less redness over the sternum; some yellowish-brown pigmentation over the upper and inner part of the left breast.

*March 7.*—She complains of a sense of constriction of the chest, but the sternum, at a point five inches below its upper extremity, moves forwards from one-half to one inch with each inspiration.

*March 12.*—The right nipple has become enlarged in a mushroom

shape, and the papillæ of its areola are rather prominent. All the affected parts are more sensitive than before to the galvanic current, and just below the left breast there is decided hyperæsthesia.

*March 23.*—There seems to be some diminution of the hardness in all the affected parts, particularly on the back, under the left breast, and above both breasts. The redness over the sternum and back is decidedly diminished.

*March 28.*—The skin of the right breast is somewhat softer, as are all the affected parts except the skin of the left breast, which is steadily shrinking. Galvanism has been applied regularly three times a week. She now returned to her home, Dr. Hopkins having kindly undertaken to continue the electrical treatment.

*April 21.*—Dr. H. writes: “The induration about the left axilla has increased, and there is now a firm band of induration, two inches in width, extending across the right axilla, and slight swelling is appearing in the right hand, forearm, and arm. . . . The sense of constriction is increasing, and there is decided shortness of breath. The induration of the right breast is increasing in firmness and beginning to contract.” He then notes an increase in the number of certain papular outgrowths which existed over the surface of the left breast, and adds, “For several days she has had constant pain, running from under the breast to the spine.”

*May 22.*—Dr. H. notes a gradual progression of the disease both in extent and in degree. “The induration upon the right side,” he writes, “has extended across the base of the axilla and the back of the scapula, and is plainly felt within an inch of the spine. On the left side the induration involves the entire upper half of the trunk. It has crept up upon the shoulder in the deltoid region from the front, and is slowly creeping up to the same region from behind and below. The left scapula is completely surrounded, and its motion almost entirely lost. The lump you saw develop near the sterno-cleido-mastoid muscle [of about the size of an almond when she left New York] has steadily enlarged, and now involves the overlying skin. The entire left breast is now covered with a highly-vascular granular tissue; the nipple of this breast has disappeared. The induration is extending down over the stomach. For the last month Miss G. has had almost constant pain of a burning character in the left breast and an increased sense of constriction over the chest. The swelling of the left arm became very painful, and I began to fear for the skin, and began the use of a flannel bandage. This has succeeded in lessening the distention and discomfort.

“The swelling of the right arm and hand is slowly increasing, and varies considerably from day to day. . . . The pain and the restless nights are telling somewhat. . . . She is out for the air almost every day, and, on the whole, looks better than you would suppose.”

*June 23.*—Dr. H. writes: “The unfavorable progress of our patient has been steadily going on. . . . The induration now in-

volves all the tissues of the trunk above the waist, and well up the neck. The left scapula is immovable, and the right one nearly so. The œdema of the left arm is intense and persistent, that of the right arm a little less so. . . . The induration is advancing upon the abdomen, and has reached the left groin, involving the left half of the abdominal wall. A hard swelling is also appearing about the left knee and in the left thigh. . . . For months the breathing has been largely abdominal, and now that is much impaired, and dyspnœa is constant, and upon the least exertion becomes very severe."

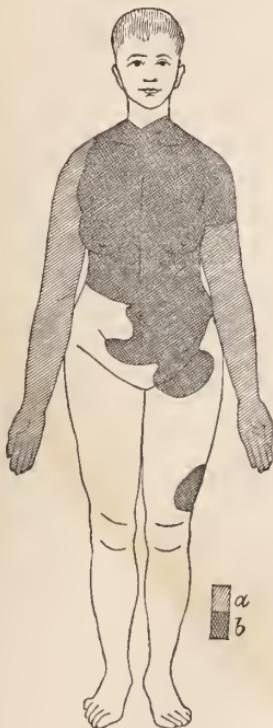
In my reply to this letter, I suggested the inhalation of compressed air as an aid to the movements of respiration, but the necessary appliances were not readily to be had, and the measure was not made use of.

*July 10.*—The doctor writes that anodynes in small doses are found necessary at night to procure quiet breathing, and that the disease is steadily progressing, and her strength failing. "The induration over the abdomen," he says, "is very uncomfortable, and will not allow her to stand erect. There is a well-marked hyperæsthesia of the left side of the abdomen, making even the most careful examination painful. I am not sure but some of the abdominal organs are indurated. The enclosed diagrams [Figs. 3 and 4] . . . show . . . the outlines."

*Aug. 22.*—Dr. Hopkins, alluding to his previous mention of anodynes, writes: "Perhaps at that time Miss G. was taking morphia, gr. ss twice a day. Well, very soon . . . there was a terrible exaltation of suffering in the way of dyspnœa, and also an excruciating pain in the region of the navel. . . . For the relief of this I began the use of morphia hypodermically . . . and have continued the same to the present time. At first half a grain was enough to give relief for a day . . . ; then, after perhaps a week, we gave two doses a day, and the quantity has been steadily increased, so that for nearly three weeks I have given six grains at a time, every four hours . . . governed solely by the effect on my patient. . . . To me the dose—thirty-six grains of the best sulphate of morphia in twenty-four hours—seems monstrous, but I have found that it is not a grain too much. I think, when I wrote you last, the abdomen was nearly all involved in the induration; at least, such has been the case for weeks, and, with the completion of this covering, the respiratory embarrassment became much more marked, and in fact [respiration] has seemed to me only possible when the system was profoundly influenced by morphia. . . . Under this condition she would breathe quietly and regularly at about eight to twelve per minute, and, save being just a little drowsy, is comfortable. Once or twice within the last month my work has kept her from having the morphia for perhaps an hour after it was due, and then I would find her with the most agonized and gasping respiration, without regularity or effect 'in' supplying air; and on one occasion I had to watch her for an hour before I

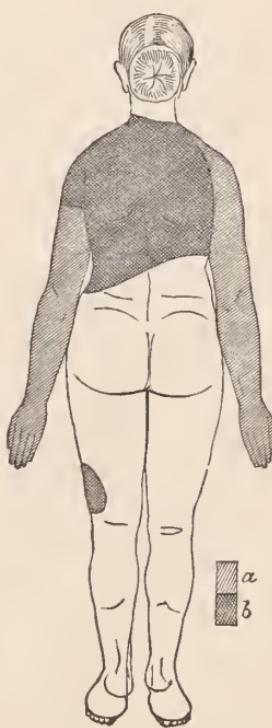
could make up my mind whether she was not dying. But with the full effect of the morphia would come partial but regular breathing

FIG. 3.



*a*, Firm induration; *b*, oedema.  
July 10, 1877.

FIG. 4.



*a*, Firm induration; *b*, oedema.  
July 10, 1877.

and a disappearance of all the threatening symptoms. . . . For the last two or three weeks I have not been obliged to increase my dose. . . . There has been gradual loss of strength and wasting of flesh, but . . . the mind has not been at all influenced."

The patient died Sept. 23, 1877. It is a matter of great regret that an autopsy was not obtained. When about to prepare this account of the case I wrote to Dr. Hopkins for additional information in regard to the mode of death, and in regard to the condition which seemed to call for the use of such large quantities of morphia. In reply Dr. Hopkins wrote: "I think I can quite confidently assure you that Miss G.'s case terminated without the appearance of any intercurrent disease. The functions of the lungs, brain, stomach, bowels, and kidneys seemed to be fairly performed up to the very last. I suppose you would say that death came from inanition,—certainly death was preceded by re-

markable emaciation. . . . For two weeks [previous to Aug. 22] I had not been obliged to increase the dose of morphia, and soon after that time I found that I could decrease the same, and did so gradually to twenty grains a day, which continued the dose to the end. . . . The induration of the skin extended in all directions, mostly downwards, covering the abdomen, back, and partially the thighs, and upwards to the hair behind and the jaw in front. It also seemed to get browner and firmer,—almost like sole leather. This was particularly marked about the left axilla, where the induration caused ankylosis of the shoulder joint and complete loss of all motions of arm and shoulder, also the most marked dropsical distention of the limb,—a distention which bid fair to rupture the skin, and, I think, was only prevented from so doing by puncturing the skin on the back of the hand and forearm. Towards the last the condition of the parts about the neck made swallowing quite difficult, and only small quantities could be slowly pushed through. During the last month, the site of the left breast was occupied by an irregular, fungating, ulcerating mass, which had a rather scant but highly offensive discharge. This was developed from the fissure at the base of the nipple, and from the point of the nipple itself. There was also a peculiar retraction of the navel, as if it were pulled by a constantly tightening string, and at the bottom of the navel was an ulcerating surface. Passing water was slow and difficult. Consciousness continued up to within a few hours of death."

In another communication Dr. Hopkins assures me that the morphia was not used on account of pain, but for the relief of *besoin de respirer.*

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### CASE OF TRICHOREXIS NODOSA, OR BEIGEL'S DISEASE.

BY S. SHERWELL, M.D.,

Clinical Professor of Dermatology in the Long Island Hospital Medical College, etc.

**M**R. V., æt. 40, a merchant, called on me, April 23, 1878, in regard to an affection of the moustache and beard with which he had been troubled for some months. He is a man of typically robust and florid health, and had a luxuriant moustache and beard.

The diseased condition of the hairs was most marked on the left side of the moustache, and extended diagonally across to and involved the opposite side of the beard more particularly, but affected hairs might be found in almost any part of the hairy face.

The clinical appearance of the disease was striking, on close observation, though at first sight the appearance was as though a caustic application had been sprinkled on the hairs, or as though

cigar-ashes had fallen among them. On closer examination the hairs had a mouse-bitten look, as if nibbled without being bitten off: there seemed to be no sign of follicular irritation, but in other respects it looked not unlike an exceptional case of trichophytosis. I cut off a few hairs and extracted others, and prepared them for examination by putting some in liquor potassæ and others in ether for varying lengths of time. After a prolonged microscopic search, on the next day, I could find no fungus or sporules, though the brush-like ends and other points had led me to expect their presence.

In the short hairs taken from the moustache, about one and a quarter to one and a half inches long, often as many as four nodular dilatations might be found, the cortical substance of which at those points seemed to be, as it were, impacted and bulged out (as described by Kaposi), and some of them reminded me of the instrument made of horsehair sometimes used to extract foreign bodies from the oesophagus; the hairs at their follicular extremities, as also between the nodules, seemed normal, except a slight tendency to an hourglass bulging and contraction of the medulla. This last, however, was not marked.

I had the patient more or less under observation for nearly six weeks, but was able to afford him little comfort as regarded a rapid cure, though fully able to disabuse his mind of his fears of contagion, he having a wife and family. A relative of his, a somewhat prominent physician of New York, had, previously to my seeing him, pronounced it an undoubted case of trichophytosis, but he had not been treated until seen by me. As I have never seen mention of any therapeutics in any of the reports I have met with of such cases, it may be well to record my own, which consisted only of the following: R.—Oleat. hydrarg. (Squibb 6%), ol. amygdal. dulcis,  $\frac{aa}{3}$  ss; ol. rosmarinii, q. s.—M. This was applied at first to the parts affected every night, then every second, third, and so on; the rationale of treatment being its mildly alterative character, and also its parasiticidal action should any necessity exist.

No marked change for the better took place while under observation at that time. The trouble seemed not to increase,—the slow growth of the hairs of the moustache would, of course, somewhat account for that,—and he ceased his visits.

In response to a note he kindly presented himself again for inspection, March 3, 1879, and though there seemed to be decided improvement, still the characteristic appearances were there; he told me he had used the treatment but little since he left, and in fact he had been always a little remiss, even while nominally under treatment, owing to his aversion to the unpleasant smell of the oleate of mercury, only partially concealed by the perfume.

At one time, shortly after my first seeing him, I imagined that I had discovered the key to the peculiar condition of the hair; it seemed that on retiring at night it was his frequent habit to take a little strong eau de cologne or other perfume in the hand and to

sweep it across the moustache and beard to conceal the odor of tobacco, he being a smoker; and I at first believed that the ethers contained in such perfumes, by beadling on the shafts of the hairs, might have removed the natural oil at such points, and thus led to the drying and separation of the fibres of the cortex. But I was obliged to give up this theory, after a time, and accept an idiopathic origin of the disease, of which I am now the more positive, as from my last observation, a few days since, there could be seen very many of the nodosities so close to the follicular exits of the hairs as to preclude the idea of this cause, he having been particular to avoid this practice ever since.

Hairs were furnished to several competent microscopists at the time of the patient first being seen, all of whom concurred with me in the non-evidence of a parasite, except Dr. G. H. Fox, of New York, who thought that in those furnished him he discovered on the shafts and adherent to them some bodies resembling sporules, though they were not of the recognized kinds; from a drawing of them which he forwarded, they would seem to resemble the microscopic roe-like masses as in the case of similar disease recorded by Drs. Cheadle and Malcolm Morris (*Lancet*, London, February 8, 1879). I am free to say that I could detect nothing in them simulating the microsporon audouini, nor, it may be remarked, is there any sign or history of alopecia.

#### AT WHAT PERIODS AND FOR HOW LONG A TIME OUGHT WE TO ADMINISTER MERCURY IN SYPHILIS?

BY CHARLES R. DRYSDALE, M.D.,

Senior Physician to the Metropolitan Free Hospital of London, and Physician to the North London Hospital for Consumption and Diseases of the Chest.

**I**N the course of this last year\* a very interesting and valuable paper was read by Mr. Jonathan Hutchinson, at the Hunterian Medical Society, on the use of mercury in syphilis. In the debate which followed the reading of this paper, it was observed by Mr. Victor De Meric that the really difficult question in treating syphilis was not whether it should or should not be given, but when and for how long it should be prescribed.

In this short paper I propose to commence the discussion of this point. It is pretty well known to all who keep themselves *au courant* with medical literature, that of late years there has been a kind of revival of experiments on the treatment of syphilis in various parts of Europe, above all, in Norway, where, indeed, mercury for some

\* This paper was received more than two years since, and being laid away at the time, from press of matter, has escaped attention until now. It is now printed, as it is well to take an occasional retrospective glance over a subject which is by no means yet decided.—ED.

time was given up by Professor Boeck and many of his colleagues and disciples in Christiania and elsewhere.

Even in Paris there took place a slight revolt in the persons of MM. Dolbeau, Després, and Perrin against the practice of using mercury, although the immense ability of Dr. Alfred Fournier has of late tended to put an end to all defection from the doctrines of his respected master, Dr. T. Ricord.

It will be remembered that in a memorable debate in the Surgical Society of Paris in 1867, Drs. Perrin, Dolbeau, and Després asserted that secondary syphilis passed through its stages, in most instances, without any special treatment; and then, if tertiary lesions were treated with the iodide of potassium in sufficient doses, nothing more was needed for the syphilitic patient.

Dr. Diday, of Lyons, was perhaps the earliest sceptic in reference to the necessity for mercury in syphilis, and in his well-known work on the natural history of syphilis he gives the detailed histories of a number of patients treated by him for secondary rashes without mercury, to all appearance with results sufficiently good to satisfy him that he was justified in being an eclectic in future.

The vehement denunciation of mercury, made by Hermann, of Vienna, Boeck, of Norway, and several others, called the attention of the profession to the results obtained by Diday, and I believe it is now well known to all competent observers that primary and secondary lesions are both very frequently mild diseases, passing through their phases without much notice by the patients in some cases, and scarcely requiring much special treatment in many instances.

Such facts are, I say, well enough known to accurate observers. I may refer those who wish to be convinced of this to the evidence of Mr. Hutchinson before the Admiralty Commission in 1866, and to Mr. Berkeley Hill's admirable volume. It may then be laid down as a fact that a majority of the cases of primary and secondary disease in adults *may* be treated without mercury without any easily-observed ill consequences *at once* arising. And, for my part, having myself treated a great number of such cases with iodine and iodide of potassium, I have to say that it seems doubtful whether many of these cases could have done better under any other treatment as far as immediate results went. It must be remembered also, that even in syphilitic iritis, Mr. Gascoyen and Mr. Ernest Hart, following in this the teachings of the late Mr. I. L. Lawrence and Williams, of Boston, still treat that most important lesion without the aid of mercury, and allege that they obtain excellent results by the use of atropine locally, and without mercury internally.

Dr. Alfred Fournier, however, in his lectures on syphilis, published last year, and the eminent surgeon, Mr. Jonathan Hutchinson, in the paper read before the Hunterian Society, have most firmly and decidedly stood up as ardent champions for the use of mercury in primary and secondary syphilis, and it is to this new doctrine that I intend to direct my earnest attention.

I am the more solicitous to attend diligently to the words of these

two very eminent syphiliographers, because I remember the time when both of them were more or less tinged with the prevalent scepticism with regard to mercury which so widely affected the profession some ten years ago.

Mr. Jonathan Hutchinson alleges that if mercury be given (in the form of gray powder, three grains, thrice daily) when the primary sore appears, the poison of syphilis may at once be destroyed, and the eruptions never appear. My own experience on this point is, I confess, too scanty, since I almost always have seen patients when the roseola or other eruption was present in company with the hard sore. Everything asserted by so careful an observer as Mr. Hutchinson should be most seriously considered; and the more so because, in his evidence before the Admiralty Commission in 1866, he mentioned having treated all primaries for a time without mercury. That, in maturer age, Mr. Hutchinson should have returned to firmer faith in mercury as a preservative from secondary eruptions is certainly a strong argument for mercury; and it has had, I confess, a strong, a very strong, effect on myself.

The next point contended for by Mr. Hutchinson is, that there are some cases of secondary syphilis of malignant type which are not amenable to the iodide of potassium, but which are curable by mercury,—e.g., rupia, in some cases.

In former days even strenuous mercurialists maintained that the drug should not be given in any cases of malignant syphilis, and the decoction of sarsaparilla and iodide of potassium were recommended. The cases cited by Mr. Hutchinson in the Hunterian Society, however, leave little doubt as to the efficacy of mercury in the deplorable forms of the disease he had to treat.

I would merely remark that such cases are fortunately of the rarest occurrence in modern times. I can call to mind only one case of malignant syphilis which died, although iodide of potassium was, I believe, used in large doses, and generous diet poured in. This case occurred in the practice of Mr. R. W. Dunn, and he had the advantage of consulting with the learned Christiania Professor Boeck. It is just within the range of possibility that mercurial treatment might have saved the life of this woman, but I confess to doubting the probability.

A far more serious charge has been recently brought forward by Dr. A. Fournier against the non-mercurial treatment of syphilis. According to that most eminent writer, the omission of mercury in the treatment of secondary rashes is the *most* important cause of tertiary disease. This he asserts distinctly in his lectures on syphilis at the Lourcine, and has just reasserted it in some further lectures upon tertiary syphilis publishing at present in the *Mouvement Médical*.

If this charge could be clearly substantiated, it would, indeed, be a death-blow to the non-mercurial treatment of any case of syphilis, which that treatment would never rally from. Before going further, then, I wish seriously to examine this point.

My own experience has long led me to say that tertiary symp-

toms may occur in any case of syphilis coming before me, and that whether the primary or secondary lesions appear "benign" or the reverse. Certainly I dread tertiary lesions rather more when the patient has had rupia or large serpiginous sores; but no one can doubt that even the mildest form of secondary eruption leaves no certainty in the mind of the practitioner that tertiaries may not appear. A good constitution, free from scrofula or consumption, is an admirable point in the prognosis of tertiaries appearing or being absent; but I have so often seen nerve-disease, or severe sore throat, in persons who have come of a healthy stock, and whose early stages have passed almost unnoticed, that I cannot give much credence to Dr. Diday's division of secondary syphilis into *benign* and *severe*.

According to Dr. A. Fournier, mercury should be used in *every case* of primary and secondary syphilis, *without any exception*, and the remedy, in the form of pills of the green iodide of mercury, should be administered for about two years, with periods of intermission, when the rashes disappear for a time, making in all some eight months of mercurial treatment. This treatment is surely too heroic to be accepted by the profession without some comment. To submit the countless host of syphilitic patients in these countries in all cases to an eight months' course of mercury is a serious undertaking, and surely not altogether without its drawbacks. It must be remembered that Professor Boeck has, in his work, "*Recherches sur la Syphilis*," given a long table of cases of syphilis treated in the Christiania Hospital, wherein he shows that tertiary syphilis, in great numbers of cases, appeared after the most methodical mercurial treatment had been used. On this point see also Després's evidence in the Surgical Society of Paris, in 1867, and his cases of tertiaries preceded by courses of mercury. Nevertheless, I am now using mercury in all cases of secondary syphilis.

In 1859 I saw a case which first of all caused me to fear the lavish use of mercury in secondary syphilis. A woman came to me who had been largely mercurialized for many months, and yet had entirely lost the sight of one eye, had nodes over the whole body, and ever since has suffered from terrible tertiary sore throat, which has on many occasions threatened her existence, although iodide of potassium has always hitherto kept her alive. She must ultimately perish of the disease. It is, then, clearly very difficult to come to any conclusion on this point, and Dr. Diday and others seem to me not far wrong when they assert that tertiary syphilis comes on quite independently of the former treatment of the disease. Here, then, the question stands for the moment, soon, I trust, to be elucidated in this grand age of positive intellects, when to propose a question is to have it speedily solved.

I ask, then, Is it true, as asserted by Dr. Fournier, that the chief cause of tertiary syphilis is the omission of systematic mercurial courses in the treatment of primaries and secondaries? and I pause for a reply.

My own experience is opposed to this conclusion ; but time alone can decide, and the *numerical* method. So much do I feel the imperative necessity of the latter appeal to further experience, that, in a paper recently read before the Lyons Congress, I ventured to recommend the appointment of a committee to solve this point, and I myself am attempting, by experiments with mercury, to contribute to its solution.

**Treatment of Tertiary Syphilis.**—Fortunately for patients affected with this grave disease, there is by no means that dissidence of opinion among the profession as to the treatment of tertiary affections that is found in the case of the earlier stages. Dr. Theophilus Ricord, following the experiments of the immortal Wallace, of Dublin (whose priceless discovery of the value of iodide of potassium in syphilis should entitle him, methinks, to a statue in his native land), has laid down clearly the indications and doses of iodide of potassium in gummy tumors and other tertiary lesions.

However excusable expectation may be, in treating syphilitic roseola, mucous tubercles, or slight secondary eruptions, in the present divided state of opinion, the practitioner who should dare to "trust to nature" in the fearful tertiary sore throat, or in ozæna, is indeed rendering himself liable to the severest charges for incapacity and ignorance. Here there is no room for delay or doubt. We must AT ONCE pour in iodide of potassium, *largâ manu*.

In such cases, too, all meddling with mercurial preparations is, I believe, out of place ; because, even if mercury be of *any* service in tertiary sore throat, which I doubt, it is far too slow to arrest the sloughing. I say this emphatically, because Dr. Hardy, of Paris, and some of his school seem to prefer the use of biniodide of mercury, even in tertiary cases.

There is, I contend, no reason to have recourse to mercury in any case of tertiary syphilis until iodide of potassium be tried in sufficient doses, of from 30 to 45 or 60 grains a day. All gummy tumors are best treated by iodide of potassium, and require no mercury. It is time enough to try mercury in those rare cases where the potash salt fails to cure.

Even then, when the iodide of potassium fails to do good to tertiary syphilis, will mercury be likely to succeed ? Alas ! I have tried it ; but often found it useless, although this would not prevent me again trying it in bad cases, for

" Melius auceps remedium quam nullam."

There is no chronological limit between secondary and tertiary lesions ; since certain accidents, such as pustulo-crustaceous skin diseases, rupia, ecthyma, and sarcocoele, may be ranged either in the late secondary or early tertiary period. Tertiary syphilis commences rarely before the second or third year, but it may reappear at any subsequent period, and that when the patient is in perfect health, even forty years after the primary sore. The lesions in ter-

tiary syphilis are rarely multiple, they come on very insidiously, and attack the parenchyma of the tissues. Thus, whilst the prognosis of secondary syphilis is good, that of tertiary syphilis is bad.

Summing up the results of this paper, I assert that—

1. Mercury should not be used in tertiary syphilis, except as a last resource when iodine fails.

2. Courses of mercury are not *proved* to prevent the occurrence of tertiary syphilis when used early in the disease. This point deserves attention.

3. Much evidence in favor of mercury in primary and secondary lesions is before the profession, but the cases requiring it have not been clearly indicated, nor has the length of time during which mercury is required been discriminated.

4. The present proposition of Dr. Fournier and W. B. Hill, etc., that courses of mercury should be continued for two years, with periods of intermission, in order to prevent tertiary syphilis, requires grave deliberation and much investigation before being accepted.

#### NOTES ON THE LOCAL TREATMENT OF CERTAIN DISEASES OF THE SKIN.\*

BY L. DUNCAN BULKLEY, A.M., M.D.,

Physician to Skin Department, Demilt Dispensary, New York; Attending Physician for Skin and Venereal Diseases at the New York Hospital, Out-Patient Department, etc.

**XXIX. Rubeola.**—Measles are mentioned here only to recall the value of inunction in this and in scarlatina. The relief given by the thorough application of grease to the whole integument once or twice daily is really very great, and there is little doubt but that it moderates the disease and has some considerable effect in diminishing the chances of the spread of the disease to others.

The mode of the application of the grease is not a very important matter, except that the body should be thoroughly anointed, and with as little friction as possible. Some advise vaseline for this purpose, some almond or other oil. The plan advocated by Mr. Milton in the first volume of these Archives, p. 222, is, in my judgment, one of the best. This consists in taking a large piece of fat bacon, soaking it well in cold water, placing in an oven, and as soon as it begins to melt, taking it out and rubbing the surface well with it, leaving the patient in the grease. This to be repeated night and morning.

\* These notes are intended to report for the use of the general practitioner the local measures in common use by the writer in the treatment of diseases of the skin. It is not intended that they shall be exhaustive, nor that the measures are recommended to the exclusion of constitutional treatment. The formulae are not claimed as original, although some of them may be. These "Notes" are continued from pages 212 and 307 of vol. ii.; pages 24, 127, and 314 of vol. iii.; pages 49, 225, and 315 of vol. iv.; and page 45 of vol. v.

XXX. *Scabies*.—If there is any one disease which more than another demonstrates the advances in dermatology during the present century, that disease is scabies, and this more than any other establishes the value of a correct diagnosis and properly devised and effectually administered local treatment. In any large collection of books and monographs on skin diseases many essays can be found discussing the subject of the *internal* origin of "the itch," and the danger of curing it by local measures, which of course are entirely refuted by the practice of to-day; and as an extreme offset to this may be placed the fact that in the Hôpital St. Louis, Paris, these cases are never admitted to the hospital, but are cured by local treatment in less than two hours, the patient then returning to his home and occupation. As a basis or model the method there employed may be briefly stated.

The patient receives a ticket which passes him to the bath-house, and prescribes the course for the itch. The clothes are all taken off, wrapped in a bundle, and while the patient is undergoing the process they are submitted to a high dry temperature in an oven, heated, I believe, by superheated steam. The patient is now rubbed from head to foot with green soap (*sapo viridis*, a strong potash soft soap) for half an hour; he then enters a warm bath, remaining in it for another half-hour, and the third half-hour is occupied by a thorough and vigorous friction of the entire body with the following ointment: R.—*Sulphuris loti.*, 5ij; *potass. carbonat.*, 5iv; *ung. simpl.*, 5ij.—M. This ointment is left on the body until the next day, to insure thorough action upon any acari which may be left, and to disinfect the clothes. The patient then, if desired, takes a bath on the following day, puts on clean clothes, and is cured, if the processes have each been conducted with sufficient diligence and vigor.

It may be somewhat difficult to carry out just this plan outside of a hospital, but with few modifications it is the one I resort to, both in public and private practice, and I tell the patients that they should be cured in a very short time if they will do their part.

Many skins in this country would be irritated to a very considerable degree by severe friction with a very strong sulphur ointment (and it is to be remembered that the pharmacopœial ointment is of the strength of one part of sulphur to two of lard), and various other measures are recommended and may be employed with good results. Especially is it necessary to use milder preparations with women and children, and perhaps the most common with me is the following: R.—*Styracis liquid.*, 5ii-5iv; *unguent. sulphuris*, 5ij-5iv; *unguent. aquæ rosæ ad.* 3ii.—M., ft. *unguent.* In strong men with tough skins I not infrequently use the ordinary sulphur ointment in full strength. The following is Hebra's ointment for scabies: R.—*Sulphuris flor.*, *olei cadini*, aa 5i; *saponis viridis*, adipis, aa 5ii; *cretæ preparat.*, 5vi.—M., ft. *unguent.* This is rather a strong application, and should not be used too vigorously on delicate skins.

One of the most difficult questions to decide often is how much

of an eruption is due to the scabies and how much to the remedies employed; for not infrequently the eruption will seem to be much aggravated and it will be thought that the disease is on the increase, whereas renewed and augmented vigor of treatment will but still aggravate the case. In such cases it must be remembered that scabies *cannot* grow much worse rapidly, and if there has really been an active application of a well-known and well-tried remedy we may be pretty sure that the disease itself is arrested, that is, that the insects are killed, and we may safely wait, and by means of cooling remedies, internal and external, such as alkaline baths, etc., as before recommended for acute skin irritation, seek to allay the artificial eruption we have excited.

But again, it may then be necessary to give another course of the anti-parasitic remedies, if there still remains any itching after the subsidence of the acute symptoms; for we must always bear in mind the possibility that the applications were not thoroughly made, as directed, or also the possibility of reinfection from some other member of the family or from the clothes.

Scabies is not at all a frequent disease in this country, but cases of it occasionally occur which are a great opprobrium to the medical attendant from want of thoroughness of the cure. Some public institutions are hardly ever free from cases of scabies.

XXXI. *Scleroderma*.—Little need be said of the local treatment of scleroderma, because, unfortunately, but little can be done internally or externally to arrest the progress of this distressing affection. The only measure which has been at all favorably reported on is galvanism, and that applied locally. I have had opportunity to follow this method satisfactorily in but a single case, which, however, yielded reasonably good results: the parts softened, and the limb and foot, which were before almost useless from the hide-bound condition of the skin, were restored to activity; when last seen, some years since, there was still, however, some of the stiffness remaining.

The mode of application consists in placing the positive pole upon a neighboring portion of healthy skin, while the negative electrode (a wet sponge or carbon) is passed over the affected part for a number of minutes, say averaging a quarter of an hour each sitting. The strength of the current is to be determined by the sensations of the patient; anywhere from five to twenty cells may be used.

Baths and emollient applications as ointments afford a certain amount of relief; my inclination would now be to employ the compound iodine ointment, used with patient friction, care being taken not to break the skin.

XXXII. *Scrofuloderma*.—Scrofuloderma, as distinct from ordinary lupus vulgaris, yields sometimes surprisingly to local treatment. Iodine takes first rank, and applications of the compound iodine ointment will occasionally give excellent results. Where greasy applications are not well borne, the compound solution of iodine will be found to be very serviceable, painted on the part or gently rubbed in.

Destructive remedies, caustics, etc., are not well borne by these indolent neoplastic growths, which either refuse to heal after their use or are followed by disfiguring cicatrices, which in turn take on the same phase of lowered vital growth.

XXXIII. *Seborrhœa*.—Local treatment must not be too much trusted to in any of the forms of seborrhœa, although the effect of local treatment is often very surprising. The subject is a very large one, and will have to be discussed in reference to the various forms in which this derangement of the sebaceous secretion occurs.

Commencing then, for convenience, with the hairy scalp, we will remember that there are two forms of the affection seen here. First, that which best merits the name, that is, seborrhœa oleosa, but which is comparatively rare, where there is a real increased flux of oily matter, which sometimes, as we have seen it, occurs to the extent of making the scalp to be almost dripping with oil; the hair is disagreeable to handle and emits an unpleasant odor. Here astringents are called for. The local treatment consists in part in frequently shampooing the scalp, and the most convenient application for this is a solution of the *sapo viridis* after the following formula: R.—*Saponis viridis*, ʒiv; alcohol, ʒij.—M. *Filtra et adde, spts. lavanduli, 5j*.—M., ft. lotio. Pouring a little on the head it is rubbed well with the fingers, a little water being sprinkled also on the scalp; this forms a good lather, which, after some further rubbing, may be washed off. Immediately after drying the hair, an ointment of tannin (5j ad ʒj) is to be well rubbed in to the roots of the hair, and to be reapplied every night. The washing is to be repeated every second or third night, or when the oiliness becomes obnoxious.

After using the ointment for a little while, say a week or so, a wash will probably serve better, and the following may be substituted for the ointment: R.—*Acidi carbolici, 5ss*; *glycerini, 5j*; *aquæ rosæ, ʒiv*.—M., ft. lotio. Or we may at once proceed with a more stimulating application, and the following will serve a good purpose: R.—*Tinct. cantharid., 5ij*; *tinct. capsici, 5iv*; *olei ricini, 5iij*; *spts. vini rectif., ʒij*; *spts. roris marinæ, ad. ʒiv*.—M., ft. lotio. Care must be exercised in using this latter, as, in a skin with much tendency to eczema, it is capable of exciting considerable inflammation, as I have witnessed.

The more common form of seborrhœa of the scalp is seen in the form of more or less oily scales, which may accumulate into considerable masses, or may, becoming dry, fall continually and form much of the dandruff often so very annoying. The local treatment of this, which is also an abnormal action of the sebaceous glands, is stimulating, like that just mentioned. If the scales are very thick and at all hard, so that washing would not remove them, the head may be first thoroughly soaked over night with some kind of oil,—and the sweet almond oil recommends itself on account of its freedom from objectionable features, as rancidity, odor, etc. The next morning it is well washed off.

The washing may be accomplished by means of the alcoholic

solution of soap previously mentioned, or tar soap, answers very well, and is indeed a very common prescription with me.

After the washing it is even more imperative to have the subsequent application used immediately, that is, as soon as the scalp is at all dry, in order that the remedy may reach the affected part before there is an opportunity for the scales to reform. In my experience about the best application is citrine ointment diluted with three times the amount of the unguentum aquæ rosæ of the Pharmacopœia, to which a few drops of an essential oil, as bergamot, geranium, or rose, may be added. Later on a small amount of cantharides may be added to the ointment with advantage.

This ointment is to be well and thoroughly rubbed into the roots of the hair; it is *not* to be put on the palm of the hand and applied as a pomade, but to be inserted with the ends of the fingers, generally by another party, deep among the hairs upon the surface of the scalp itself. The ointment is to be thus rubbed in daily, and the head may be washed as frequently as the greasiness of the scalp demands, generally twice or three times a week.

But I have seen cases where I believed that the disease was kept up by too frequent washings, and I give a caution to that effect.

The stimulating washes previously given are equally applicable in this dry form of seborrhœa capitis, and may be used with advantage. Sometimes ammonia suits the scalp better, and the following prescription will be found of great service: R.—Tinct. capsici, 5iv; liq. ammoniæ, 5ij-3iv; glycerin., 5ij-5vj; aquæ rosæ, ad. 3iv. M., ft. lotio.

When the scalp is tender, and when the scales continue to form after this treatment, the following mild and very soothing wash, if continued for some time, will prove ultimately successful: R.—Plumbi acetat., gr. viij; olei ricini, 5iv; olei bergam., 5ss-5j; spts. vini rectif., 3lijss.—M., ft. lotio. But it must never be forgotten that seborrhœa is a local manifestation of general weakness, and that constitutional remedies are necessary to a cure.

(To be continued.)

## CLINICAL REPORTS.

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### I. Unusual Case of Tylosis Palmaris et Plantaris. By L. DUNCAN BULKLEY, A.M., M.D.

Miss A., aged 25, a small, rather poorly developed and delicate young lady, came under treatment April 9, 1879. She states that she has had the present condition of the palms and soles since infancy, and that her father and paternal grandfather had also the same: likewise a brother of her father. Ten years ago she began to have subacute articular and muscular rheumatism, and has suffered from this much of the time since; two years ago she was confined to the bed for three weeks with it. Her menses began at between thirteen and fourteen years of age, and have been irregular since and accompanied with much pain; her attending physician says that she has retroversion, the uterus being low down and very tender on pressure.

She has been under much and varied treatment, and for a long time was under the care of the late Mr. Startin, of London, for her hands, but without effecting any marked or permanent improvement in their condition. At times she has had deep-seated abscesses beneath the epidermal masses, which have been very painful.

Her condition at the first visit, which was much the same as now, may be thus described:

Both palms and soles are the seat of immense and evenly distributed epidermal thickening, extending, on the hands, from the wrists to the tips of the fingers, and on the feet from the heels to the ends of the toes, and to a slight degree reaching on to the sides of the members. These masses are of a yellow color, horny, stiff, and unyielding, and the palms give a hard, woody sound when rapped upon. From time to time the surface cracks and may be the seat of deep fissures; the hands are almost useless from the disease, as well as nearly crippled with rheumatism. From the soles considerable masses of epidermis may be lifted up, but the surfaces of the palms are in the main smooth and even, though where cracked through the epidermal mass may be slowly separated from its bed by tearing.

The condition of the palms has improved very materially under the use of hot water and diachylon ointment, with anti-rheumatic remedies internally. The feet are treated by wearing oiled silk within the stockings night and day. The patient was obliged to return to England after a few weeks' treatment, and further results cannot be stated.

II. Case of Dermatosclerosis simulating Elephantiasis Arabum.  
Under Care of DR. H. S. PURDON.

ELLEN MORELL, æt. 44, by occupation a nurse, was admitted to Belfast Royal Hospital, April 2, 1879. She is a married woman, and has ten children, the age of the youngest being ten years.

After her third confinement, about twenty years ago, her left leg was the seat of an inflammatory swelling, which, from the description given, seems to have been of the nature of "phlegmasia dolens." Under treatment it soon regained its normal size, and there was left no trace of the existence of the inflammation.

About six years ago her right leg was the seat of an erysipelatous inflammation. It did not affect the thigh. This in about two months got well, but some thickening of the skin remained.

About one year after, the erysipelas attacked the left leg, there being the same limitation as to extent as in the right. On the subsidence of the inflammation some swelling remained. The left leg has since twice been the seat of erythematous redness, each attack leaving some extra thickening. The right has been similarly affected on five occasions.

At present the thigh of the left lower extremity measures 31 inches in circumference; the leg of the same, 22 inches. The thigh of the right, 28½ inches; the leg of the same, 23 inches. The left arm, 18½ inches; the forearm, 12½ inches. The right arm, 17½ inches; the forearm, 12½ inches. Weight, 224 pounds.

Dr. H. S. Purdon made the following remarks: We have in this case an hypertrophy of the skin and areolo-fibrous tissue, especially well marked in the thigh and legs, while in the arms as yet only an excessive deposit of adipose tissue. The attacks described as erysipelas bear a considerable resemblance to the "rose," as observed ushering in an attack of elephantiasis in Barbadoes. These attacks of erysipelas have been painless, but frequently recurring, however, subsiding without any desquamation. To the touch the skin of the lower extremities feels thickened, pitting on pressure of the finger, leaving a mark similar to that produced by pressure on a bladder of lard. Cruveilhier has noted the great oedema of limb consequent upon obstruction of the femoral vein, such effusion occasionally becoming more or less solid; whilst Dr. Meigs has also known the enlargement of the extremity caused by phlegmasia dolens to persist for years. Rhazes long ago pointed out that there are two forms of Arabian elephantiasis,—the white and smooth, and the brown and coarse; the former caused by "phlegm," or lymph, the latter by dark blood and knotted veins. In the first form the disease gives rise to degeneration of muscle, and often affects the bones; whilst in the second the skin is chiefly more involved, stretched, fissured, and scaly. The fat in the lobules becomes coarse, and seems to be removed from the immediate neighborhood of the integument, to be deposited in thick layers below the fascia and among the muscles; hence our patient, not only from her weight, but from the degen-

erated state of her muscles, has for some time been unable to walk. Erasmus Wilson has well remarked regarding the disease under notice, that in the production of dermatosclerosis "we recognize the consequence of exhausted vital force on the one hand, and on the other a feeble nutritive or reparative reaction, which results in the reproduction in excess of the lowly-organized connective or fibrous element, constituting in fact a state of fibrous degeneration."

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III. *Clinical Conversations on Diseases of the Skin.\* By THE EDITOR. Reported by Dr. W. T. Alexander, Clinical Assistant.*

CASE I. *Syphilitic analgesia.*—You have frequently seen me prick the skin of patients presenting various forms of syphilitic eruption to ascertain the presence or absence of a symptom which was pointed out by Fournier ten years ago as of not infrequent occurrence in the secondary period of this disease. The condition sought for is what is known as analgesia, or a loss of the sensation of pain, and you will find it strikingly marked in this young man before you. As you perceive, I can thrust this pin entirely through a fold of the skin, pinched up on either forearm, without causing him much pain, and when this was first tried some weeks ago he did not feel it at all. This condition exists also on the hands, and he does not feel it when I thrust the pin into the thigh.

You notice that the arms and most of the body are covered with the stains of a bygone eruption, which was evidently composed of small papules, quite thickly set, while here, especially on the extensor aspect of the arms, we have a new eruption, composed of much larger elements, a papulo-pustular one, with some little disposition to crusting. Examine carefully just above the internal condyles of both humeri and note the marked enlargement of the epitrochlear glands, an almost constant accompaniment of this early secondary eruption of syphilis. You also get an adenopathy in the back of the neck. He likewise complains considerably of soreness of the throat, and on examination the pharynx is seen to be red and congested, with some superficial mucous erosions here and there.

Besides the value in demonstrating to you the analgesia of syphilis, this case is instructive as illustrating the difficulty you will occasionally find in treating syphilis. This young man, Thomas G., aged 22, has been under treatment for more than two months, and yet in the face of a very fair amount of mercury taken with a very reasonable faithfulness, we find a new eruption manifesting itself, while the stains of the first eruption are still very clear; we find also an amount of throat lesion which gives considerable annoyance, and also distinct general adenopathy and marked analgesia. And such cases are by no means entirely exceptional, for I can recall a number of instances, both in public and private practice, where an amount of mercury

\* Cases shown and remarks made to private classes, Demilt Dispensary, New York.

which might be considered large on the average has failed to check the disease.

The first eruption faded very rapidly soon after the commencement of treatment, but now that new lesions have presented themselves, we will direct him to use, in addition to his mixture, which is as follows: R.—Hydrarg. bichlor., gr. j; potass. iod., 5iv; ferri ammon. cit., 5j; tinct. nuc. vom., 5ij; tinct. cinchon. co., 3iv, inunctions of the unguentum hydrargyri, diluted with an equal part of simple ointment. Of this he will rub a little well into a soft portion of the skin every night, and we will caution him to cease this if the gums or mouth should become in the least tender.

When Fournier first described the analgesia of secondary syphilis, ten years or more ago, he dwelt specially upon its occurrence in women, mainly because his main experience was largely gained in the Lourcine Hospital, which is for female venereal patients. But it occurs equally in males, though possibly less frequently, because of a stronger nervous organization. It is not always present, even in those cases presenting general eruptions early in syphilis, as you have frequently seen me fail to find it, and I cannot tell you of any particular significance which it has; it is as yet only an interesting clinical feature observed in certain cases early in syphilis, and does not, as far as I know, indicate anything in particular, though I should incline to think that it rather belonged to those cases in which there was a profound impression made by the syphilitic poison.

CASE II. *Acute papular eczema*.—Eczema is so constantly associated in the minds of the profession with vesicles that few of you would at first be prepared to call the eruption before you by this name. But if it be borne in mind that eczema is essentially a polymorphous eruption, capable of assuming the characters of very many other diseases, that it may appear and run its course as an erythema, or as a papule, or, as in the palms, that there may be simply thickening and fissures, etc., you will be better prepared to make a correct diagnosis.

This man, Frank B., a bricklayer, aged 22, first noticed a papular eruption appearing on the arms and abdomen five weeks ago, which lesion has continued to develop and increase until the present time. You now see a considerable portion of the trunk and extremities covered with an eruption of small papules, intensely congestive, inasmuch as they disappear largely on pressure; you will notice that the flexures are affected much more severely than the extensor surfaces: the papules, which are quite thickly set, are in places gathered together in patches, and on some of them you may already observe a desquamation. There is great itching and burning over the whole surface.

He tells us that he has been taking sulphur internally and using a sulphur ointment to the eruption, which latter well accounts for the acutely inflamed condition of things. You know that sulphur is thought to be "good for skin diseases," and you would really be surprised to see how continually it is advised by patients, druggists,

and even physicians, in the most varying eruptions. Now, while in chronic conditions of the skin it oftentimes does serve as a good stimulant, in the acutely inflammatory condition or in a newly-developing eruption it is worse than useless, it is positively harmful; the only exception to this being in the case of scabies or "the itch," where it has a parasiticidal action, and even here it may occasionally create a very considerable artificial inflammation and hinder the progress of the case.

Let this case, then, be a warning to you against employing sulphur unnecessarily, for we may safely say that a large share of this irritated, distressing condition of the skin is due to the remedies he has employed.

We will order him a laxative composed of blue mass, compound colocynth extract, and ipecac, and give him tolerably full doses of acetate of potassa, to relieve the cutaneous congestion, and with a little weak zinc ointment (gr. xxx ad  $\frac{3}{4}$ i) we will find that the eruption will fade rapidly. Later, I would give him locally the oil of cade mixed with cod-liver oil ( $\frac{5}{4}$ i ad  $\frac{3}{4}$ i), which is an excellent application where a large surface is involved, but it would be much too stimulating at the present time.

CASE III. *Lupus erythematosus*.—This woman, aged 27, presents a lesion the true nature of which was long a doubtful question among dermatologists, and indeed, there is yet very much to learn in respect to it. Bearing in mind the older descriptions of what was called lupus, remembering perchance some case where great destruction of tissue and disfiguration of the patient had resulted from lupus, one would hardly be prepared to give the same name, even when modified by *erythematous*, to such a picture as is presented by this patient.

Both cheeks and the nose are seen to be the seat of a reddened integument, presenting sharply-defined borders, and almost perfectly symmetrically developed. It requires no great stretch of imagination to liken the appearance to a butterfly, the body being represented by the nose, while the two patches on the cheeks answer to the wings,—a comparison frequently made by Hebra.

On close examination certain portions of this eruption are seen to present a very curious appearance, which is peculiar to this disease. This is a certain blocked-up condition of the sebaceous follicles, which are each seen to be filled with a horny plug; and where this has been removed artificially, as by treatment, you see the mouths of the follicles gaping, and evidently surrounded by infiltration. I have likened them in this state to a wax preparation into which numerous pin-holes had been made, so unyielding does the surface appear. When such cases are not treated locally a certain amount of crusting will form on the surface, and on removing this its under surface will be seen to be covered with minute prolongations, which represent sebaceous plugs which have been drawn from the dilated follicles.

So striking is this sebaceous feature in certain cases, that Hebra

originally described the disease as seborrhœa congestiva, and it is only comparatively recently that microscopic study of sections of skin taken from these cases has established it as a variety of lupus.

But although a variety of lupus you need not look for any of the destructive results which are associated with that name; this eruption generally leaves a superficial cicatrix, which is often very slight indeed, but sometimes quite disfiguring, though it never reaches beneath the tissue of the skin itself. You will notice that this surface is very even and uniform, it has none of the separated and isolated pulpy tubercles which characterize the ordinary lupus, lupus vulgaris, which you know is sometimes seen in a very superficial form; nor has this any of the flat epithelial scales, attached quite firmly on one side, which you see in lupus vulgaris.

To those not specially acquainted with skin diseases syphilis always occurs to the mind at once as a cause; suffice it to say syphilis never presents any lesion which could resemble the case before you, even in the slightest degree. There are few, if any, sensations in this eruption; she says it does not itch, but burns a little occasionally; this alone would exclude eczema, which in this locality especially is distressingly itchy. Besides, this has never been moist at all, nor scaly, nor fissured; and on pinching up the surface you get very little thickening, a prominent characteristic of eczema on the face. I cannot think of any other eruptions with which you should confound it.

Unfortunately, the treatment in this, as in most cases of this disease, has not yielded any very good results as yet. The eruption is essentially a chronic one and often resists treatment amazingly; in this case the eruption has certainly spread under various measures which have been employed, although now it seems to be at a standstill.

Internal remedies have little, if any, effect in checking the disease, although sometimes improvement will seem to follow them. This woman is now taking the eau de bourboule, the French natural arsenical mineral water, and there has been some improvement since it was employed, but I would by no means yet recommend its use until further investigations have been made.

Locally she has used the compound tincture of green soap followed by zinc ointment, and at first I thought there was some improvement under it, but afterwards the eruption spread greatly under its use. She now finds that the sulphuret of potassium and zinc lotion (R.—Potass. sulphuret., zinci sulphat.,  $\text{aa } \frac{3}{i}$ ; aquæ rosæ,  $\frac{3}{iv}$ ), which I prescribe so frequently in acne, cools the face greatly, and under it the eruption certainly appears much less pronounced; but lupus erythematosus is a disease about which a hasty judgment can never be formed.

## SOCIETY TRANSACTIONS.

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### NEW YORK DERMATOLOGICAL SOCIETY.

*Ninety-seventh Regular Meeting, November 26, 1878.*

THE following cases were exhibited before the Society:  
**Lupus.**

DR. PIFFARD presented two cases of lupus for the purpose of exhibiting the result of treatment.

The first case—Maria M.—was the patient that had been exhibited by Dr. Bulkley at the last February meeting of the Society (reported on pp. 230 and 231, ARCHIVES OF DERMATOLOGY, July, 1878). The patient had been first seen by Dr. Piffard in December, 1877. She, however, did not come under his care until last May, at which time she presented substantially the same appearances as described in the report referred to.

On the 24th of May Dr. Piffard removed the affected portions by scraping, followed by galvano-cautery and the application of chloride of zinc.

*June 14.*—All healed and everything looking well.

*July 21.*—Decided evidences of relapse in isolated portions of original lesion.

*July 30.*—Operated again by scraping and application of chloride of zinc.

*Aug. 21.*—All healed and looking well, except a nodule in right upper lid, near inner angle; nodule seems subcutaneous.

*Oct. 7.*—Two small ulcerations on nose, at upper and lower portions of original lesion.

*Nov. 26* (night of the meeting).—Ulcers healed and nodule in upper lid gone. Internal treatment, in the beginning, was cod-liver oil and tincture of helianthemum, followed by bromide of arsenic with a little gold; nothing from August 21 to October 7; subsequently, small quantities of arsenious and silicic acids.

The second case—Margaret W.—had a patch of lupus on left temple, near the eye; lesion, 1.5 centimetre in diameter, consisted of a periphery of nodules, with central depression and small adherent crust. Without anaesthetic, and assisted by Dr. McMaster, removed the lesion at the clinic, May 14, 1878. The connective

tissue beneath the skin appeared healthy, so no caustic or other application was made; simple dressing.

May 30.—Wound healed.

Nov. 26.—Still healed, and no sign of relapse.

On microscopic examination, find lesion to consist chiefly in diffuse, small, round-cell infiltration, no stratified cell-nests, thus excluding epithelioma.

DR. PIFFARD considered the first case as a tubercular lupus, with superficial ulceration; the second, a lupus erythematosus.

DR. KEYES remarked that the first case had been shown him some time after the operation, and that, from the presence of certain tubercles still remaining upon one lid, he believed that another operation would become necessary. If a cure had been effected by internal treatment alone, he thought it remarkable.

DR. BULKLEY, who had previously seen the first case, considered it epithelioma and not lupus. The very fact that it had healed under the treatment pursued showed that it was not lupus; the age of the patient—43—was in favor of epithelioma, and not lupus. He thought, from the present appearances, that the disease would return. In such cases of epithelioma he much preferred Marsden's paste to the spoon.

DR. PIFFARD said that his diagnosis had been confirmed by other physicians, and in the second case he had ascertained by microscopic examination that the characteristic elements of epithelioma were absent. He did not rely on the spoon alone in treatment, but supplemented it by cauterization. In regard to internal treatment he was not prepared to make very positive assertions in regard to the effect of the silica, which had been given in extremely small doses, but during its use the ulcerations had entirely healed, and the remains of the disease, more especially a tubercle upon the eye-lid, had almost entirely disappeared.

DR. BULKLEY presented a patient with an eruption resembling the

### True prurigo of Hebra.

The man was 44 years of age, and had suffered from his eruption for seven years. The points of resemblance to prurigo, as shown by DR. Bulkley, were the presence of solid papules on the legs, without more redness than could be accounted for by the scratching, the intense and uncontrollable itching, and induration of the glands in both groins. The history of the case militated against the diagnosis prurigo, and it was not claimed as a typical case, but was shown as a case presenting no little difficulty of diagnosis, and one which might prove to be the disease in question. The whole cutaneous surface was abnormally red, and there was some evidence of chronic eczema about the hands.

DR. FOX thought that the inflammatory nature of the papules, and the fact of the disease developing in adult life, pointed to some other affection than the prurigo of Hebra.

DR. SHERWELL believed that the induration of the glands in the groins were not sufficiently marked for a case of true prurigo.

DR. ROBINSON remarked that the glandular swellings were not greater than might be expected to occur with any considerable irritation of the extremities. He would regard it as a form of chronic erythema.

DR. BRONSON thought the case failed to answer to the prurigo of Hebra, both in its history and in the character and location of the lesions. The peculiar papules were much smaller than those in the present case, while the thickening over the affected surfaces was much more marked. Attention was called to the erythematous redness of the hands, face, and legs, not a feature of prurigo. As to the location, in prurigo the peroneal surfaces of the legs were affected, whereas here there were large, smooth, and red papules on the inner aspect of the legs. He should regard the case as a form of chronic erythema, with the characters of erythema papulatum in certain places.

DR. BULKLEY said that while he admitted that there were obvious points of dissimilarity between this case and true prurigo, as he knew it in Vienna, he claimed that certain allowances should be made for the modifying influence of country, etc. Prurigo in America would not necessarily follow the same course or present the same traits as in Austria. Many of the symptoms in the present case were accidental, or secondary. The redness, which, he observed, was very general over much of the body, did not constitute an erythema, but was purely a peculiar congested condition of the skin, an accidental complication.

DR. FOX remarked that while not admitting the diagnosis prurigo in this case, he believed that true prurigo in a mild form was not such a very rare occurrence in this country. The cases which many present had studied in the clinics at Vienna were generally cases of prurigo ferox, and it was too often forgotten that a mild form of the same disease is described by Hebra, under the name of prurigo mitis.

DR. FOX showed a case of chronic universal eczema of five years' standing in an elderly man.

DR. SHERWELL presented a patient with cervical adenitis, with a syphilitic history.

DR. BULKLEY introduced a patient with a

#### Peculiar Eruption on the Legs.

The patient, a woman aged about 50, had had the present condition in varying severity for several years previous (six or seven, she asserted), there having never been any more active lesions than those present; that is, there had never been ulceration, nor any itching or anything to call attention to the part. Both legs were the seat of what at a little distance would readily be considered the remains of a tubercular syphilide. There were small, dark copper-colored spots grouped together about the anterior aspect of the lower

legs, two-thirds of the surface of the left leg being thus covered. On closer examination, the very slightest scaling was observed, and they appeared to be only the remains of a former lesion. But the case had been under the observation of Dr. B. for a number of months, and these spots had been the same, only new ones forming from time to time. He believed the lesion to be an alteration in the capillary blood-vessels, akin to that taking place in varicose veins.

DR. KEVES thought that enough points were present to justify a tentative antisyphilitic treatment. The color, grouping, and peculiar scales on the lesions, together with a suspicious bursal enlargement upon the knee, were in favor of the disease being syphilis. He referred also to the fact that there had been superficial exfoliation of one of the bones of the foot which had healed. Such an accident was unusual, at least in adults, and would imply a specific cause.

DR. BULKLEY said that he had gone over the case very carefully, and had failed to find anything corroborative of syphilis; the loss of bone was due to an injury.

DR. FOX said that next to the diagnosis of syphilis he would entertain that of lichen planus, to which he thought the case presented considerable resemblance. There was itching, and he had seen a grouping similar to this in that disease. In one case well-marked annular rings as large as a quarter of a dollar were scattered over the body and extremities.

DR. TAYLOR thought the diagnosis lay between syphilis and lichen planus; the itching, however, might be accounted for by the varicose veins. He had seen syphilitic eruptions which had lasted twelve years. He would try an antisyphilitic treatment here.

DR. FOSTER showed a case of

### Melanosis cutis.

It existed on the middle of the lumbar region in a woman 35 years of age, and presented a group of slightly elevated, smooth, purplish-black masses, with one ulcerating patch about the size of a quarter of a dollar; scattered around this were about a dozen smaller masses, varying in size from that of a pin-head to a good-sized bean. There was some enlargement of the right inguinal glands. The disease had developed in a cicatrix following a burn in this location, received when a child.

DR. KEVES advised complete excision, together with removal of the inguinal glands.

DR. FOSTER had not proposed to operate, because he did not believe that such a measure would affect materially the course of the disease; it probably existed already in the internal organs.

DR. KEVES thought that extirpation was indicated to remove this focus of disease, whence morbid elements may disseminate.

The Society adjourned for an extra meeting at the expiration of two weeks.

*Adjourned Ninety-seventh Meeting, December 10, 1878.*

The regular order of the evening was the reading of a paper by DR. MORROW, on

### A case of urticaria pigmentosa.\*

DR. TAYLOR had had a case under his care about eight years ago, which was very similar to the case just described, and which had been exhibited recently before the Society. Urticular wheals formed rapidly and turned into erythematous patches or circumscribed papules; some of the patches faded away while others persisted. Sometimes as a patch faded away a thickened yellowish spot like xanthoma would be left. This case had been regarded as syphilitic by other physicians. He had also seen another case where repeated attacks of urticaria were followed by pigmented spots.

DR. FOX thought the adjective *pigmentosa* less appropriate to Dr. Morrow's case than to the London cases mentioned in the paper. In Dr. Morrow's case the pigmentary element was comparatively slight and unimportant. As to the permanency of the tubercles, he believed that they gradually receded after a time, and regarded further observations as to their duration important. By Dr. Morrow's courtesy, he had mapped out certain of them to watch them, but could not report on them now.

DR. BULKLEY believed the case to be identical in its nature with the cases abroad, cited in the paper. He referred especially to one of Dr. Tilbury Fox's cases, which he had recently an opportunity of seeing with Dr. Fox in London. It differed in some respects from Dr. Morrow's; the patches were large, flat upon the surface, and showed a decided thickening. They were of a brownish fawn color, which had suggested to Dr. Fox the name he had applied, *xanthelasmaidea*; it was the case figured in Dr. Fox's atlas.

DR. FOSTER agreed with Dr. Fox that the name *pigmentosa* was not very well chosen, inasmuch as the pigmentation was not an essential characteristic; the peculiar feature appeared to be rather an hyperplasia, and he would prefer the term *urticaria hyperplastica*. A similar condition sometimes follows smallpox, and may occur after vaccinia. Elevated hyperplastic patches are formed, which may last for two or three months.

DR. MORROW explained in regard to the pigmentation that it varied with the season. During the winter the spots faded and assumed a light buff color, but in summer the pigmentation was much more pronounced.

DR. TAYLOR exhibited a copy of Joseph Grünpeck's monograph on syphilis, the second work ever written on that subject, then called French disease, entitled: *Tractatus de pestilentiale scorrasive mala de Frantzos, originem remediaque eius continens. Compi-*

\* Published in Archives of Dermatology, Vol. V. No. 1, January, 1879, p. 26.

latus e Venerabili Viro Magistro Joseph Grünpeck de Burkhausen, super carmina quædum Sebastiani Brandt utriusque Juris Professoris.

At the end of the dedication is the date 15th November, 1496. On the title-page is a woodcut of a girl covered with pustules.

Brunet speaks of this work as being very rare indeed, and Girtanner (*Abhandlung über die Venerische Krankheit.*, 1789) says that copies of it are in the Mazarini Library in Paris, in the Sarelli Library in Vienna, in the Hamburg, in the Wolfenbüttel, in the British Museum, and in the library at Tübingen.

Grünpeck speaks of mercurial ointment, and a gargle for ulcers of the mouth caused by inunctions of it.

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Ninety-eighth Regular Meeting, January 28, 1879.

DR. BRONSON presented a case with the diagnosis of

### Lichen planus.

The patient was a woman aged 26 years. The parts affected were the anterior portions of both axillæ and the adjoining portions of the arms and shoulders. There were disseminated papules across the back, at the base of the neck, and several clusters on the neck. The eruption was papular, the papulæ in places being aggregated into uniform patches; the smallest papules were of very minute size, and each one showed a red base and glistening summit. Some of the larger ones showed the effect of scratching. In several places the papules had coalesced, and formed smooth, red, flat, slightly-raised patches, with striæ marking the surface. In a few places the surface was denuded of epithelium, was exuding, and presented a decidedly eczematous appearance.

DR. ROBINSON observed that while a number of the papules bore a strong resemblance to the characteristic lesions of lichen planus, the location of the disease and the history of its short duration, together with the fact that certain portions of the eruption were unmistakably eczematous, would lead him to regard the disease as a papular eczema.

DRS. SHERWELL, MORROW, FOSTER, TAYLOR, BULKLEY, and STURGIS maintained that the disease was simply eczema.

DR. FOX said that there was undoubtedly an eczematous element present. He thought, however, that the peculiar purplish, flattened, and glistening papules seen in this case were unlike anything he had seen in eczema.

DR. BRONSON regretted the artificial light, which changed the appearance very materially; had he first seen the case to-night he would not have ventured the diagnosis lichen planus. It was certainly not a good type of that disease, and might after all be only a form of eczema. But this would at least imply a close resemblance between certain phases of the two diseases, if not something akin in their pathology.

DR. FOX showed a case of

### Recurrent exfoliative erythema.

The patient was a young man, who in childhood had suffered from annual attacks of cutaneous hyperæmia, followed by a peeling of the entire skin in large flakes as in scarlatina. During the past six months he had had similar attacks in a milder form, from one of which he was just recovering. The skin of almost the entire body had exfoliated during the past ten days, and the horny layer of the epidermis of the palms was absent in patches, leaving a thin, dry, reddened skin beneath. Shreds or flakes of epidermis were still adhering tightly, and could be peeled off without causing pain.

DR. BULKLEY observed that he should regard it identical in character with a case which he had presented before the Society a few meetings previously.\*

DR. OTIS recalled a case where an erythematous eruption of the hands was associated with a general papular syphiloderm. The epidermis exfoliated in large strips over the hands, presenting much the appearance seen in this case. The erythematous eruption was confined to the hands. The patient was taking mercury.

DR. TAYLOR had seen a case where the administration of mercury was invariably followed by the production of an erythema annulare, which commenced in a small spot on the back of the hand, between the roots of the thumb and forefinger, and gradually invaded the whole cutaneous surface. In another case, a similar result always followed the external application of tincture of arnica.

DR. FOX remarked that his case was not the ambulant form of erythema, but it began as a general disease over the entire surface, and desquamation followed in from four to five days.

DR. BULKLEY observed that in his case there was marked enlargement of the lymphatic glands.

DR. BULKLEY then read a brief history of a patient brought by Dr. Gibney, with

### Scleroderma, hemiatrophy facialis, and alopecia areata.†

The discussion of the case was deferred until a future meeting of the Society, when the subject of the relations between scleroderma and morphea should be taken up in connection with the histories of all the patients exhibited before the Society.

DR. TAYLOR read an extract taken from an old medical journal, giving an account of

### Leucoderma in the Indian.

While leucoderma is far from uncommon in the negro, the fact that its occurrence in the Indian is not mentioned by writers leads me to suppose that it is rare in that race. While reading the first

\* Archives of Dermatology, Vol. IV. No. 3, July, 1878, pp. 226, 235.

† Reported in full, Archives of Dermatology, Vol. V. No. 2, April, 1879, p. 155.

volume of the Transactions of the Physico-Medical Society of New York, published in this city in 1817, I chanced to find an article entitled *An Instance of a change of Color in the Skin of an American Indian*, by Emery Bissell, M.D., of Clinton, New York, communicated to the Society by Dr. J. Knight, Professor of Anatomy at Yale College, and corresponding member of the Society. As the case is so interesting and unique, and has remained forgotten for more than half a century,—no mention having, as far as I know, been made of it in the text-books,—I take the liberty of presenting a brief history of it to the Society. It is possible that if attention is now directed to the subject, physicians in the Western countries, who see large numbers of Indians, may be led to report any similar cases which they may meet. Dr. Bissell writes as follows: The subject of this singular phenomenon is Samuel Adams, belonging to the Brotherton tribe of Indians, living near Clinton, New York. He is now 90 years of age, and has been gradually becoming white for the last thirty years of his life. He is remarkably vigorous and healthy, cultivates his land, and rides on horseback. He so well retains possession of his mental faculties that I have no hesitation in giving full credit to the statement which he has made to me of the facts connected with the present subject.

From his own words, corroborated by the testimony of several of his relatives, I obtained the following account of the first appearance and subsequent progress of this singular affection. The skin began to undergo a change of color at the age of 60, very soon after an attack of rheumatism. The first appearance was a small white patch near the scrobiculus cordis. Soon after this spots of the same color occurred on different parts of the body and limbs, gradually increasing both in size and number. He says he was at this time greatly alarmed, and visited the different mineral springs in this State in the hope of removing a color so odious. Finding these measures ineffectual, and being convinced that no danger was to be apprehended from a white skin, he relinquished the idea of regaining his native color, and (to use his own words) "patiently submitted to become like the white men in everything but their dishonesty."

Since it commenced the change has been constantly going on, though not in a very uniform manner; at times progressing very rapidly, at others remaining stationary. These irregularities seem never to have been influenced by the season of the year, as the same have occurred at all seasons. The original color at this time remains only on the forehead, forepart of the face, and neck, with a few small patches on the arms.

The skin on the body and lower extremities is perfectly white, soft, and pliable, having nothing of a dull, chalky appearance; neither does it possess the livid hue generally observable in the skins of albinos, but is remarkably fine and clean. It has, in fact, a much nearer resemblance to the delicate skin of a female than to that of a man of "fourscore years and ten."

In those parts which have become white perspiration has always been somewhat less than in others. They are more sensitive, being much more susceptible to the effects of heat and cold, and are often blistered by the heat of the sun. They are likewise very tender, and bleed much when cut or lacerated, and heal with difficulty. The hair has undergone no other change than is incident to old age, being moderately gray. His general health was good, but he had slight trembling of his limbs, occasioned by a paralytic shock which occurred eight years ago. Adams affirms that he never was in his life before afflicted with any cutaneous disease except the itch, and that but once or twice; that his complexion was much darker than is common among those of his own race; or, as he says, he "was a very black Indian."

Dr. Bissell states that he inquired carefully among the older members of the tribe whether they had ever seen or heard of such an affection occurring in other persons, and the reply was that they had not, nor had they ever heard of an albino among the Indians of that locality. He says, however, that they are found among the Indians of the Isthmus of Darien, and of other places in that latitude.

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*Ninety-ninth Regular Meeting, February 25, 1879.*

DR. MORROW presented a patient with

### Morpheæ,

affecting the right shoulder and arm. The patient, an Irishwoman, 35 years of age, had had the disease for about twelve months. The principal patch of the disease was situated over the region of the deltoid muscle. It is irregularly circular in shape, and measures one and a half inches in a line corresponding to the long axis of the limb, and two inches transversely. The skin has a white, waxy appearance, exactly comparable to the surface of leaf-lard, and is marked by minute transverse corrugations, which give it a glazed and shining aspect.\*

DR. FOX remarked that he had seen and studied the case previously, and he believed it to be a true case of morpheæ. He had seen several other cases like this, all bearing certain characters in common, implying one and the same disease,—a disease which did not answer to scleroderma, but reasoning by exclusion, could, he believed, only be morpheæ.

DR. PIFFARD was doubtful about the cases. In his own experience he had never yet met with any case to which he should apply the term morpheæ.

DR. MORROW referred to Liveing's description of the disease, to which, he maintained, the present case corresponded very closely. He particularly called attention to the local elevation of tempera-

\* Reported in full, Archives of Dermatology, Vol. V. No. 2, April, 1879, page 158.

ture, which was greater by eight-tenths of a degree than that of the surrounding surface as ascertained by the surface thermometer.

DR. PIFFARD thought that the indications of the surface thermometer could be relied upon only to a limited extent. The surface temperature was too much exposed to sudden variations to infer much from thermometric indications at any time.

DR. MORROW explained that it was not the absolute temperature that he relied upon, but only the relative temperature as compared with the surrounding parts.

The chairman of the Committee on Scleroderma and Morphœa not having arrived with a report, the discussion of the subject was deferred till later.

DR. FOX related the following as an instance of

#### Prolonged syphilitic inoculation.

The patient first presented himself a few weeks after connection, with an herpetic eruption on the prepuce, together with some balanitis. There was at this time no trace of induration, and nothing which could be called a chancre. The trouble healed under simple measures, but recurred. In about two months from the time the patient was first seen, and precisely two months and two weeks after the last connection, a slight abrasion appeared, with a certain degree of induration, which rapidly developed into an undoubted initial lesion of syphilis.

DR. KEYES mentioned the case of a patient with a chancre which he had regarded as a well-marked instance of the form described by Fournier and others as the herpetic chancre, and of which this case of Dr. Fox's appears to have been an example. The patient had been subject to attacks of herpes preputialis, for which he was in the habit of frequently seeking advice. Shortly after his marriage he presented himself again with what to all appearance was only another herpetic attack. He was nervous about it owing to the fact that a short time before marriage he had had connection with a prostitute. The herpes did not go away as usual, but after continuing for some ten days or two weeks ulcers appeared, which coalesced and became indurated. A very malignant form of syphilis followed.

DR. BRONSON related a case in which the second period of incubation was unusually prolonged. A patient presented himself with a sore in the sulcus coronæ glandis, which showed a well-marked induration. He was carefully watched for developing symptoms of syphilis; but, though seen at intervals of a few days, or not more than a week, no syphilitic manifestations were discovered until a period of six months had elapsed. Then there appeared a few scattered spots of erythematous eruption over the body, which were slightly raised, and of a coppery or dusky-red color, not symmetrical, and one or two little ulcers about the anus or nates, and angina with mucous patches in the fauces. The ulcers near the anus

had not the appearance of chancres, and soon healed. The patient had not had connection since the time he was first seen.

DR. SHERWELL referred briefly to a case of exfoliative dermatitis of the palms and soles which had recently come under his observation.

DR. BRONSON presented specimens of iodoform paste, which had been prepared with a view to diminish or disguise the odor of the drug. It was formed by rubbing the powdered iodoform with equal parts of mucilage and glycerine in sufficient quantity to make a soft mass, and then adding a minute quantity of some essential oil; for this latter nothing had been found better than oil of peppermint, which had been recently suggested in one of the German periodicals. The proportions in the specimen shown were as follows: R.—Iodoform, 5j; mucilag. cum glycerina, gtt. xx; olei menth. pip. (seu neroli, seu carophylli), gtt. j.—M.

*One Hundredth Regular Meeting, March 25, 1879.*

DR. MORROW presented a case of

### Papular eczema

of the forearms, occurring in a boy 12 years of age. Attention was called to the absence of vesicles or moist exudation. The eruption consisted of small, hard, acuminate papules, scattered thickly over the posterior aspects of the forearms.

DR. SHERWELL read the notes of a case of

### Trichorexis nodosa, or Beigel's disease.

It occurred in the person of a gentleman, aged 40 years, whose moustache and beard had for some months been the seat of the peculiar swellings or nodosities characteristic of the disease.\*

DR. PIFFARD maintained that the disease described and named thus by Kaposi was not a new one, but had been abundantly described long ago. He quoted from Gruby, Brazin, T. Fox, Malassez, and others, to show that all the essential points of the disease had been fully recognized. He believed the bulgings on the hairs were not due to parasitic growth, but to localized fatty degeneration.

DR. ROBINSON had examined the hairs in one case, but had failed to find any fungus.

DR. SHERWELL reported a case of severe

### Chronic pemphigus

of fourteen years' history: once or twice during that time the patient had been free from the eruption eighteen months to two years. The last attack had lasted six months, and had been cured

\* See full report in this issue of Archives of Dermatology, page 240.

by inunctions of oleum lini, together with the internal administration of the ground seed. The treatment had lasted twenty-two days, during which time a gallon of the oil had been used every five days, the patient being kept soaked with it in bed.

DR. WEISSE referred to a case of ichthyosis in a child presented by him before the Society some months before. The disease had undergone no marked change since; the child was now six years old. He also spoke of excellent results he had lately obtained in acne pustulosa from the sulphide of calcium, in doses of half a grain three times daily.

DR. PIFFARD remarked that he thought that dose of sulphide of calcium too large if the drug were pure. Alarming symptoms had sometimes followed the administration of large doses. The sulphide was readily changed by exposure to the air, and for that reason much of that found in the shops was more or less inert. He had found it convenient to administer the remedy in tablets consisting of the sulphide triturated with sugar in the proportion of one to ten. He had also used a solution of the sulphide of ammonium of the strength of one to ten parts; of this he gave one drop three times daily.

DR. WEISSE said that he had been very particular in securing a good quality of the sulphide, and had never seen any bad results from the dose used. He gave it rubbed up with white sugar.

DR. TAYLOR was in the habit of prescribing it in solution with glycerine and water, equal parts. He believed that this preserved the strength of the drug, and was very convenient; he had used it to a considerable extent and with very good results. He usually gave from one-sixth to one-third of a grain at a dose; more than one-third of a grain was apt to be attended with burning of the stomach and dizziness.

DR. PIFFARD showed a new form of epilating forceps which he had devised; the peculiarity of it was that the biting edges were parallel to the axis of the blades, instead of at right angles, thus enabling the instrument to be held horizontally to the surface to be epilated, instead of vertically, the advantage being that it did not obstruct the view. He also showed specimens of Chalmoogra oil.

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*One Hundred and First Regular Meeting, April 22, 1879.*

DR. SHERWELL presented a case for diagnosis bearing some resemblance to Hebra's

**Prurigo ferox.**

The patient was a girl 18 years of age, who had suffered from an itching eruption more or less during her entire life, but at times was free from it, once for a year or more. The feet, legs, and thighs were nearly covered with a red, eczematous eruption, which did not extend above the hips. There was great enlargement of the glands

in the groins, and the itching was intense. Some portions of the eruption were very distinctly papular.

DR. FOX thought that the large amount of eczematous surface, the absence of the characteristic shotty tubercles of prurigo, and the fact that the eruption was not confined to the peroneal surfaces, excluded the diagnosis of prurigo. The glandular enlargement present was the direct effect of the irritation produced by the eczema and the scratching, and was not pathognomonic of prurigo.

DR. BULKLEY believed the case to be one of chronic eczema. The mother had stated to him that for several years the disease had been absent, which would not have been the case were it prurigo. He referred to the case presented by himself a few months ago,\* which had simulated prurigo, but was really only chronic papular eczema. The case had since almost entirely recovered, and was still under treatment.

DR. ROBINSON considered it simply chronic eczema.

DR. BRONSON said that he believed it was rare to see prurigo accompanied by such violent eczema as presented in this case. Although eczema often co-existed, it was of less acute character than here seen, and was seldom such as to preclude the very severe stimulating measures of treatment usually adopted in that disease.

DR. SHERWELL stated that the affection had undergone decided modifications since first seen by him. At that time it was much more like prurigo than at present. There were then certain dry, shotty papules without moist surfaces, and confined to the localities of prurigo. The patient's stories were inconsistent; she had told him that the disease had never been absent. From the present appearances he would certainly agree with the opinions which had been expressed.

DR. ROBINSON showed a case of

### Chronic lymphadenitis.

The patient was a man 30 years old, on whom there were three or four small, movable, pea-sized, or somewhat larger subcutaneous tumors, on the nates, hip, and neck. Most of them appeared to be unconnected with the skin, though over two of them (one on the right hip and one on the neck) the skin was adherent. These latter were marked by a darkish-brown discoloration, the others were of the color of the normal skin. There was no history of syphilis. The patient had been treated with the iodide of potassium internally and oleate of mercury externally.

DR. BULKLEY believed that the growths were unquestionably due to an affection of the lymphatics, and certainly not syphilitic. The affections of the lymphatics had been until recently almost entirely ignored. There were now two well-recognized lymphatic affections of the skin, lymphadenoma and lymphangioma. Kaposi describes the latter as a nævus of the lymphatics, his observation being based on one case. Lymphadenoma had been written on by several

\* Ninety-seventh Regular Meeting. See page 259.

writers, and was now a well-recognized lesion of the skin ; such would he regard this case. In this disease there was a slow increase of lymphatic elements, not properly a hypertrophy of the glands themselves ; the tumors did not pertain to the larger and well-recognized lymphatic glands, but were found in various parts of the skin.

He recalled two patients with this affection. In the first one there was a series of subcutaneous tumors about the upper and lower lip and chin, associated with acne rosacea ; the lady was of an extremely bilious temperament. The swellings were of various sizes, some being as fine as small duck-shot, others the size of a pea ; they were very often felt to be in connecting chains ; some of them were deep-seated and externally of the color of normal skin, others were purplish red. Iodide of sodium would cause their rapid disappearance. The second case was the patient recently presented before the Society with recurrent exfoliative dermatitis of the hands and feet.\* For a considerable period of time he had been having from time to time deep-seated lumps, sometimes in chains, especially about the face. These were sometimes normal in color, but occasionally certain of these would approach the surface, become of a dark red color, and occasionally suppurate ; they were entirely painless, and were to be perfectly distinguished from any of the forms of acne. Some of them would last from four or five weeks to several months. They were certainly not syphilitic. He would hardly regard such cases as identical with the mycosis fungoïdes of the French, as in neither of them was there any ulceration.

In the first case he had excised one of the nodules from the chin, and would ask Dr. Robinson for a report on its nature, as it had been submitted to him for microscopic examination.

DR. ROBINSON had found the mass composed of lymphatic tissue. He felt quite certain of the connection of this disease with the lymphatics, but concerning its precise nature he would not express an opinion.

DR. SHERWELL observed that the tumors in the patient presented were not unlike gummata, but suggested also the possibility of their being latent sarcoma.

DR. BRONSON thought that the evidence of the tumors being of a lymphatic nature was not conclusive. He believed, however, that a variety of diseases might produce subcutaneous growths that could not be distinguished from these. He had been unable to perceive that there was any connection between the tumors corresponding to a chain of lymph-glands.

DR. STURGIS would regard the tumors as either fibrous or lymphatic ; he would exclude sarcoma and gumma.

DR. FOX referred to the frequent application of the term lymphadenoma to large tumors occurring about the neck and elsewhere.

DR. BULKLEY said that he referred only to lymphadenoma cutis.

\* Archives of Dermatology, Vol. IV. No. 3, July, 1878, pp. 226, 235.

DR. ROBINSON presented a case for

### Diagnosis.

The patient, a man of about 50 years, presented numerous, rather extensive, rounded patches upon the top of the scalp, showing a reddened, thickened, and scar-like surface, entirely devoid of hair. It had existed five years, and it was stated that there had never been any preceding ulceration. The hairs upon the edges of the patches were of normal appearance and firmly rooted. A little desquamation was noticed about the patches at times. The cicatrices looked very much like those produced by favus, but a corroborative history was absent, and no traces of the parasite could be discovered by the microscope.

DR. BULKLEY referred to a case precisely similar which had lately been under his observation and treatment. In that case, as in this, he believed the affection to be an eczematiform syphiloderm. In his case there were raw patches, without real ulceration and without any hardened edges. The eruption had healed under specific treatment, and the hairs were being reproduced in part.

DR. FOSTER inquired if there was the same cicatrical condition as in this case.

DR. BULKLEY replied that there was a condition simulating cicatrical growth, but he would hardly call it true cicatrix; the lesion was more superficial than the ordinary ulcerating of the head, and corresponded with what had been described as an eczematiform syphiloderm.

DR. BRONSON cited a case very similar to the one presented, in which it was possible to exclude syphilis with considerable positiveness. The patient was a young boy, in whom there was not the slightest suspicion of venereal disease. In this case the denuded scalp was redder than in Dr. Robinson's case. There was some desquamation in the vicinity, and though the hairs were not loose nor broken off, he had suspected parasitic disease, but could obtain no confirmation of this.

DR. ROBINSON had examined the scales in his case, and had found no parasite. He believed that it had been improving under proto-iodide of mercury internally, and oleate of mercury locally.

## DIGEST OF LITERATURE.

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### I.

#### DISEASES OF THE SKIN.

#### ANATOMY, PHYSIOLOGY, AND PATHOLOGY.

A. R. ROBINSON, M.D.

**The histology of psoriasis.**—Mr. ALLAN JAMIESON summarizes the literature of the subject, and details at length the results obtained by Dr. A. R. Robinson. He then describes his own investigations, the main result of which was to establish the accuracy of Dr. Robinson's observations, and to further confirm them by additional arguments. It seemed to him, however, that although the increased activity of the cells of the rete preceded the changes in the vessels and the transudation of the colorless blood-cells, the latter persisted for a time after the cells of the rete had undergone retrograde changes. In this unimportant point he differs from the view of Dr. Robinson. The paper closes with a discussion of the action of arsenic in psoriasis, the conclusion reached being that this drug stimulates the cells of the epidermis to exhaustion, so that destruction overruns construction.—*Edinb. Med. Jour.*, Jan. 1879, p. 622.

**The cause of the alterations in the internal organs of animals consequent upon the suspension of perspiration.**—The most inoffensive means of suppressing perspiration, such as varnishing with gum arabic, albumen, or dextrine, cause death. If the varnishing be complete, morbid symptoms develop rapidly, the animal trembling and becoming restless. The respiratory movements, at first accelerated, become slow, and the temperature falls. Albumen appears in the urine, the excretion of carbonic acid is lessened, and the heart's action weaker. In some cases convulsion occurs, and finally the animal dies. If the animal be kept in a high temperature or enveloped in cotton, the morbid symptoms disappear and recovery follows. When the varnishing is partial the temperature rises immediately, and continues high for several days. The morbid symptoms come on gradually, albuminuria in two days,

and increases till death, when hyaline and granular fatty casts appear in the urine. At the approach of death the temperature falls, the respiration becomes slow, and convulsions occur. Death always follows where but little more than one-sixth of the whole surface is varnished.

LOMIKOWSKY attempted to find the cause of the inflammation of internal organs, which so constantly occurs, by subjecting healthy animals to intense cold. He observed that they acted just as did animals that were varnished, and that parenchymatous inflammations also occurred. He therefore regards as untenable the theory which had been abandoned until revived by Sakolow, that death was due to poisoning by some retained excretion, and believes that it is owing to the great loss of heat and its consequences. The elevation of temperature observed immediately after partial or total varnishing is the inevitable result of this great loss.—*Journ. de l'Anat. et de la Physiol.*, July and Aug. 1878, p. 468.

**A further contribution to the anatomy of the syphilitic chancre.**—UNNA sums up the conclusions arrived at from his researches as follows:

1. The fibrillary constituent of the cutis, which by its hypertrophy causes the hardness of the chancre, consists of pure collagen.
2. The induration of the initial lesion of syphilis arises from fibrillary hypertrophy of the connective tissue of the adventitia of individual vessels, with disappearance of the lymph-spaces, complicated with round-cell infiltration, and similar changes in the perivascular tissues.
3. In hard chancre the endothelial growth in the vessels is not the primary change, the constant and early participation in the morbid process of the vasa vasorum making it probable that this is the starting-point of the disease. Where there are no vasa vasorum, the process always begins in the adventitia.
4. Acute endarteritis obliterans syphilitica differs from chronic in the radiating, not concentric, arrangement of the connective tissue, and in the lack of organization.
5. A possible result of long-continued initial sclerosis is a gummy induration, the development of miliary gummata in indurated connective tissue, with central cheesy degeneration. In this retrogressive process giant cells are sometimes found, which is never the case in the typical initial sclerosis. In three cases in which the chancre was excised only one developed secondary symptoms after more than a year. The author denies the histological identity of hard chancre and gummy formations.—*Viertelj. f. Dermat. und Syph.*, v. Jahr., Heft 4, 1878, s. 543.

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## INFLAMMATIONS: ACUTE AND CONTAGIOUS.

ROBERT CAMPBELL, M.D.

**Septicæmia and scarlatina.**—The following interesting case is reported by FFOLLIOTT: a private soldier, by the accidental explosion of some gunpowder, was severely burned on the left hip and inside of the thigh, and on the arms and face. On the fourth day after the accident there was considerable constitutional disturbance; a bright scarlet rash made its appearance on the abdomen, which spread over the whole body. The next day the eruption was very vivid, resembling a boiled lobster. Several medical officers who saw the case pronounced it scarlatina. The eruption continued for five days, and then declined gradually. After the eruption appeared, the febrile symptoms disappeared, the temperature becoming normal. The highest temperature recorded was 101 degrees, and was at the commencement of the attack. The tongue was slightly furred, never at any time becoming red, nor was there any soreness of the throat or enlargement of the tonsils. The cuticle desquamated over the entire body, as in true scarlatina, the palms of the hands and soles of the feet not escaping. There was no scarlatina in the camp at the time. Ffolliott says that there can be very little doubt that the absorption of the septic poison into the circulation is capable of producing a scarlet rash on the body; but doubts very much if it is capable of transmission by infection, and thinks if such were the case, it would be found to be true scarlatina.—*British Med. Journal*, April 5, 1879, p. 505.

**Scarlatina.**—Dr. MINOT reports a case of scarlatina in an infant. The mother and two children had had a very severe attack of the same disease two months previous to the birth of the child, whom Dr. Minot saw, showing that the infant was not protected.—Proceed. Boston Soc. for Med. Observation; *Boston Med. and Surg. Journ.*, Jan. 23, 1879, p. 126.

**Vaccination followed by death.**—Dr. PETERS, of Roxbury, Mass., reports a case of death following vaccination. The virus

was bovine, fresh, and of the best quality. The vesicles were perfectly developed on the eighth day. On the fourteenth day, when the patient was next seen, the space occupied by the three vesicles, with the skin around it, was black and sloughing, forming a deep ulcer two and a half inches long, and more than an inch broad. There were superficial ulcerations elsewhere on the arm, and three blebs filled with turbid, serous fluid. The affected arm was twice the size of its fellow, boggy, and oedematous. There was a vivid redness of the skin at the shoulder-joint and half-way to the sternum. Marked constitutional disturbance on the three days succeeding the constitutional symptoms grew worse, while the arm was improving. The urine became scanty and high-colored, the face was white and puffy. On the morning of the eighteenth day these symptoms were improved, and the child appeared to be better; the arm was now rapidly healing. A little later in the day the patient was seized with a chill, the skin turned bluish, and the child soon died. The patient lived near the neighborhood of a marsh. In the discussion which followed, the opinion prevailed that death was due to erysipelas, and that the child was not enjoying perfect health when vaccination was performed.—Proceed. Norfolk Dist. Med. Soc.; *Boston Med. and Surg. Journ.*, June 26, 1879, p. 894.

**Vaccination in India.**—From a report of the sanitary commissioner for Madras it appears that the total number of vaccine operations performed during the year was 483,192, being an average increase of 101,780 on the results of the previous year. On an average, 94.33 per cent. of the cases operated on were reported as successful. The number of children vaccinated under one year of age was 52,505. The people have a fear of infants undergoing the operation, and usually defer it till the children can run alone.—*British Med. Journ.*, Nov. 9, 1878, p. 698.

**The power of carbolic acid to abort the pustulation of smallpox.**—Dr. A. R. PLATT makes use of the following to prevent pitting in smallpox: R.—Acid. carbolici, 5iss; glycerin., aquæ, aa 5i; to be applied frequently and freely to the face, neck, and arms, and to have the entire body sponged twice daily. He reports good results.—*N. Y. Med. Record*, March 22, 1879, p. 284.

**Another ectrotic in smallpox.**—SEMARIA claims that if smallpox pustules are first pencilled with glycerine and then powdered thickly with a mixture containing four parts of sulphur and precipitate, there will be no cicatrices resulting.—*Gazette Med. Ital. Lomb.*; *New Orleans Med. and Surg. Journ.*, Sept. 1878, p. 228.

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## INFLAMMATIONS: ACUTE AND NON-CONTAGIOUS.

JAMES C. WHITE, M.D.

**Erythema in typhoid fever.**—RAYMOND AND NÉLATON report several cases of a scarlatina-like rash occurring late in the course of this affection, of which the following is a description by Dr. Saundby. On the fifteenth day of the fever an eruption appeared on the arms, the neck, and the chest, consisting of papules and patches, irregular in size and shape, slightly elevated above the surface, and disappearing on pressure. Amid this eruption the ordinary lenticular rash could be recognized. On the following day the eruption was general. The soles were covered with rounded, bright red papules of the size of a lentil. On the leg these were of variable dimensions, and there were rosy patches of various size, which contrasted sharply by their elevated borders with the healthy skin. On the face were a few little rounded elevations, confluent and forming patches and serpiginous bands of a red color. Over the back, wherever pressure was exercised, there was a uniform redness resembling that in erysipelas. On the second day the red patches became at first violet, much darker, then grew pale and resembled the copper color of syphilitic eruptions. At the end of a week the rash had disappeared in many places. On the face, neck, and abdomen there was a branny desquamation, but on the chest particularly and on other places the epidermis came off in rounded scales. On the hands and feet it fell in large patches. The authors state that these were not cases of scarlatina for the following reasons: the form of the eruption and predominance in certain parts unusual in that disease; the absence of prodromata, angina, and the peculiar tongue; and the course followed by the desquamation, which was limited on the trunk, arms, and legs to the raised papules, simulating urticaria. They also believe that the eruption differs in most respects from the different varieties of rashes or erythema hitherto described in typhoid fever.—*London Medical Record*, Dec. 15, 1878.

**Surgical erythema.**—Dr. CHEADLE, of London, offers the following points of difference between certain scarlatiniform rashes in various traumatic conditions and true scarlet fever. There is no swelling of the tonsils, no enlargement of the glands, although the fauces may be reddened. The tongue never presents the strawberry appearance. It is furred, perhaps, but the coating has not the whitish or yellow tint seen in scarlatina. The rash is often not universal, but confined to the body and the parts covered by clothes, the face being free. Sometimes it is in more or less distinct patches, with portions of comparatively clear skin between. It rarely lasts more than twenty-four hours, and is never followed by desquamation; it is not sufficiently intense, and its duration is too short. Not

unfrequently, however, a positive conclusion between surgical erythema and the slighter forms of scarlet fever is impossible without delay.—*British Med. Journal*, Jan. 1879.

**Quinine eruptions.**—Dr. FARQUHARSON, in his lecture on the various forms of skin-irritation due to the administration of drugs, divides those resulting from the use of quinine into two classes. The first are erythematous, attended by most distressing itching and tingling, and resembling scarlatina, both in the appearance of the rash and the subsequent desquamation. The second assumes a more measly aspect, being occasionally papular, but more generally suggestive of that form of urticaria which occurs not in wheals, but in discrete rose-red patches of universal distribution, and attended by gastric disturbance. Half-grain doses even have been enough to produce the rash. A large proportion of instances of this idiosyncrasy have occurred among females.—*British Med. Journal*, Feb. 22, 1879.

**Quinine efflorescence.**—NEUMANN reports the case of a young woman upon whom after large doses of quinine an eruption showed itself of universal distribution, which was at first called scarlatina and later erysipelas. After the discovery of its true nature and the omission of the drug, the efflorescence disappeared in the form of an exfoliation of several weeks' duration, accompanied by abscesses and furuncles. Owing to her debilitated state the quinine was ordered again and again, but each time it was followed by the cutaneous inflammation, beginning in the face and extending over trunk and limbs. Neumann calls the eruption an erythema exudativum diffusum.—*Viertely. für Derm. und Sylph.*, VI. Jahrg. 1 Heft; from *Wiener Med. Blatt*.

**Eruptions from chloral.**—MAYOR records five cases in which the administration of chloral in affections of very various nature was followed by definite symptoms of a uniform order. They came on after eating, beginning with redness of the face, excited action of the heart, and dyspnoea. The redness spreads to the neck; the palms, and sometimes the soles, being also affected. The eruption then appears on other parts of the body, and especially on the dorsal surface of the hands and wrists, the superior and anterior part of the thorax, the exterior surfaces of the knees and elbows, and the dorsum of the foot. It lasts from half an hour to a few hours, with itchiness of the part affected, and is followed the next day by slight desquamation. The spots are of a deep rose color, are sometimes slightly elevated, and have sometimes a sinuous border.—*La France Médicale*, No. 3, 1879, and *London Med. Record*, April 15, 1879.

**Atropine in urticaria.**—SCHWIMMER reports three cases of obstinate chronic urticaria which yielded rapidly and permanently to the internal administration of atropine in small doses. Its action is explained, if we regard the affection as an angioneurosis,

by its specific effect upon the ganglionic system, as it is supposed to produce a paralysis of the vaso-motor centres. In one of the cases a co-existing hyperidrosis was also temporarily relieved, which is also supposed to be dependent upon disturbance of the vaso-motor nerves.—*Viertelj. für Derm. und Syph.*, VI. Jahrg. 1 Heft; from *Pester Med.-Chir. Presse*, 1878.

**Catamenial erysipelas.**—Dr. WAGNER reports three cases of this character, of which he finds but one other recorded in medical literature. The first of these was a girl 16 years old, who from the age of 14, when she began to menstruate, had been attacked four or five days before every catamenial period with facial erysipelas. The beginning of the flow, which took place about the height of the disease, had no apparent effect upon the cutaneous inflammation, which ran its course in about eight days. These repeated attacks had caused her to become completely bald, but otherwise she was in perfect health. She remained under Dr. Wagner's care for three years, during which various methods of constitutional treatment were employed, but without in any way changing her condition in this respect. His second patient was a girl 17 years old, who had first menstruated six months previously. The flow was preceded for five days by an erysipelas of the face, which rapidly subsided with the appearance of the catamenia. After a few months the menstruation became more regular and the cutaneous manifestations ceased. A year afterwards, as the menses again became irregular, the erysipelas returned during two periods. In the third case the woman was in her climacteric period, and during the attending irregularities of the discharge the catamenia were preceded each time by a facial erysipelas, until she ceased to menstruate. Dr. Wagner calls attention to the fact that in the first instance the erysipelas accompanied a physiological process, while in the last two it was dependent upon disturbances of menstruation, and mentions in explanation of the phenomena the terms "reflex neurosis."—*Cincinnati Lancet and Clinic*, March 29, 1879; from *Allg. Med. Central-Zeitung*, No. 94, 1878.

**Idiopathic recurrent erysipelas.**—In a clinical lecture upon this common affection, Dr. BULKLEY expresses a doubt as to the propriety of calling it erysipelas, on account of the differences between it and the form which results from wounds and is epidemic in hospitals. The variety in question is that which so often occurs upon one side of the face in connection with nasal catarrh. He regards it as a true lymphangitis, and that its prevention is to be effected by a cure of the catarrh.—*Archives of Clinical Surgery*, Jan. 2, 1879.

**Experiments on malignant pustule.**—M. COLIN, at the Academy of Medicine, described a series of experiments made to ascertain the means of neutralizing various forms of virus in the animal system. Forty rabbits were inoculated with the virus of

malignant pustule. The inoculation was done at the tip of the ear, which was cut off ten minutes afterwards. The disease developed itself, however, in every instance, nor did the virus lose any of its energy throughout the series of experiments. Various substances were injected to neutralize the poison, as tincture of iodine, carbolic acid, sulphuric acid, hyposulphite of soda, borax, sulphate of iron, and sulphate of quinine, but all the animals died within forty-two hours after the inoculation. Davaine had found that these substances neutralize the virus in a watch-glass, but Colin's experiments show that their action is not the same in the organism. In each case swelling of the spleen and bacteria in the blood were determined.—*Med. and Surg. Reporter*, Feb. 15, 1879.

**Herpes of the genitals.**—Dr. LANDE reports three cases of this affection and offers the following comments upon its nature. He believes that it is not most commonly due to local irritation, but is a special disease analogous to zoster. The eruption is often preceded by neuralgic symptoms for a few hours or three or four days even, the intensity of which is in no way proportionate to the extent of the former. The pain generally ceases with the appearance of the vesicles. The neuralgia is of three varieties, sciatic, testicular, and urethral. In women pain analogous to the testicular form is felt in the ovary of the affected side before the eruption. The author proposes for the affection the name *herpès neuralgique génital*, and attributes it to inflammation or hyperæmia of the sacral plexus.—*Journal de Médecine de Bordeaux*, March 22, 1879.

**Herpes of the inside of the cheek and tonsil.**—Dr. INGLEBY MACKENZIE reports the case of a lady with left dorso-pectoral zoster, in whom there appeared during the retrogression of the efflorescence a well-developed crop of vesicles upon the inner side of the left cheek, accompanied by much swelling of the face. They exactly resembled those upon the chest, and were collected in a "racemose patch." Three days subsequently she complained of a sore throat, and a similar group of vesicles was discovered upon the left tonsil. The efflorescence ran the ordinary course of herpes.

—*British Med. Journal*, March 1, 1879.

**Acute pemphigus.**—BEYERLEIN, in an historical sketch of pemphigus in general, states that the acute affection is rare and is observed in children almost wholly. It lasts from eight to fourteen days, but may prolong itself by relapses to three or four weeks. Recent observations show that it is not the result of syphilis or a cachexia, that it is contagious and generally epidemic, when it affects not only infants but also older children. In exceptional instances this contagious infantile form has transferred itself to adults.—*Med.-Chir. Rundschau*, Jan. 1879.

**Phlyctenoid eruptions.**—Prof. GERHARDT describes, under the title "remitting fever with phlyctenoid eruption," the case of a patient, who, with general febrile symptoms, exhibited a wide-spread

eruption of grouped vesicles, of large bullæ with more or less haemorrhagic contents, and of brownish-red, large, macular patches. The spleen was enlarged, and the efflorescence did not complete its course for a month. Gerhardt believes that several instances have been recorded of a similar affection under a variety of names. Kapozi publishes an open letter to Gerhardt concerning the case, maintaining that it is one of herpes iris only, and stating its relations to erythema multiforme, urticaria, etc. To this Gerhardt replies, stating the difference in the temperature curve of his case and erythema multiforme, and repeating his conviction that it is an independent affection.—*Wien. Med. Wochenschr.*, 28, 30-35, 1878, and *Viertelj. für D. und S.*, VI. Jahrg. 1 Heft.

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## INFLAMMATIONS: CHRONIC; SQUAMOUS, PRURIGINOUS, AND PUSTULAR.

W. T. ALEXANDER, M.D.

**Contribution to the study of the local treatment of psoriasis.**—BESNIER states that the treatment of psoriasis by arsenic does not prevent relapses. Until within a few years the best local treatment was the use of oil of cade; but chrysophanic acid has proven itself a better remedy, the principal objection to which is the staining that it produces. Pyrogallic acid, in his experience, is not inferior to any other local remedy, and appears to have certain peculiar advantages. It has no bad effects, and its action, though slow, is effective, and it produces but little irritation. The brown color which it leaves disappears in a few days, and it has no unpleasant odor. He uses it in the form of a salve, in the strength of five to twenty-five per cent., rubbing it on, after removing the epidermis by soap, every two or three days. This treatment was always followed by relief, which was usually permanent.—*La France Méd.*, March 12, 1879, p. 161.

**Eczema of the tongue and buccal cavity.**—HARDY details a case of this disease occurring in a man who did not use tobacco, which was characterized by white patches on the dorsum of the tongue and inner surfaces of the cheeks. The patches were surrounded by small scattered spots of thickened epithelium and a few shallow ulcers. The diagnosis was rendered certain by the co-existence of eczema in other parts of the body. The disease yielded to arsenic internally and a weak carbolic acid lotion locally.—*Gaz. des Hôpitaux*, 1879, No. 7; *Med. Chirurg. Rundschau*, April, 1879, p. 285.

**A contribution to the treatment of psoriasis.**—PREISMANN calls attention to the urgent necessity for removing the scales before applying a remedy to the diseased spots, and speaks of the difficulty of doing this thoroughly. For this purpose he was led to use, and now highly recommends, a solution of salicylic acid in alcohol, one part to sixteen. When this solution is rubbed lightly upon a patch with a cotton swab the scales instantly become loose and fall off, leaving the patch red, dry, and even. It also removes the grease

and renders the action of the subsequently applied medicine much more efficacious. The lotion acts very efficiently in relieving the itching, and he has found it useful in chloasma, lentigo, etc.—*Wien. Med. Presse*, 1879, 16, s. 514.

**Injection of carbolic acid in prurigo.**—FLEISCHMANN uses, with great benefit, a two per cent. solution of carbolic acid, injecting subcutaneously at first one-half, subsequently the whole of the contents of the syringe.—*Révue des Sciences Médicales*, January, 1879; *Dub. Jour. of Med. Science*, March, 1879, p. 206.

**Impetigo contagiosa.**—VAN HARLINGEN inoculated himself with fluid from the vesicles of impetigo contagiosa and covered the part. In forty-eight hours a vesicle appeared, from which successful re-inoculation was practised. They all disappeared in two weeks. Impetigo contagiosa is distinguished from impetigo simplex by the fact that in the former the initial lesion is a superficial vesico-pustule, somewhat like a vaccine pustule, whereas in the latter it is a true pustule, deep-seated.—*Phila. Med. and Surg. Repor.*, Sept. 8, 1878; *Edinb. Med. Jour.*, April, 1879, p. 955.

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## PARASITIC DISEASES.

J. EDMONDSON ATKINSON, M.D.

**On acarus folliculorum.**—J. NEUMANN has studied the acarus folliculorum as found in the skin of dogs and pigs. He concludes that while this parasite occasions no irritation in the human skin, it is quite otherwise with these animals. Here the symptoms are much graver. In the pig, from 100 to 200 acari were found in a single follicle. They were also found in the scales and crusts of a portion of skin removed from a dog. The symptoms occasioned in these beasts were milium-like eruptions of the size of millet-seed, hard, semi-spherical, and of a yellowish color, as well as tubercles and pustules, and superficial ulcerations.—*Auz. d. Ges. d. Aerzte in Wien.*, No. 7, 1878; *Wiener Med. Wochenschrift*, 50, 1878; *Ann. de Dermat. et de Syph.*, 2, 1879; *Viertelj. f. Derm. u. Syph.*, 1 Heft, 1879, p. 151.

**The comparative growth of the fungi of favus and ring-worm.**—Dr. HOGGAN selected the hair in following out his investigations of ringworm. Three stages of growth were recognized by him. In the first stage a single layer of ringworm-fungi grow beneath the one-celled layer of hair-cuticle, without apparently disturbing the latter. Next, the hair-cuticle becomes raised and thrown off, like the bark from a tree; and finally, the shaft of the hair becoming exposed, the fungus penetrates between the cells, disintegrates them, and destroys the hair. The favus fungus, on the other hand, grows beneath the epidermis, and in separating it from the dermis forms circular "crusts," the fungus thriving in the serum derived from the dermic papillæ.—*Path. Soc. Lond.*, Dec. 17, 1878; *Lancet*, Dec. 28, 1878. \*

**The condition of the skin in tinea tonsurans.**—Dr. FREDERICK TAYLOR's paper is based upon an examination of a ringworm patch upon the skin of a patient dead of tubercle of the cerebellum. Dr. Taylor asserts that the fungus does not extend beyond the upper end of the hair-bulb. The hair-papilla is never invaded. The spread of the fungus is limited, laterally, by the inner root-sheath, with which the spores, in advanced stages, are in contact. The outer root-sheath never shows traces of fungus, nor do any other of the neighboring tissues. His conclusion is that the fungus invades the hairs proper, but never advances beyond the bulb nor attacks the root-sheaths. These results conform with those of Dr. George Thin, a synopsis of whose paper "On the Condition of the Skin in Tinea Tonsurans" will be found in the ARCHIVES for January, 1879.—*Royal Med. and Chir. Soc.*, Nov. 12, 1878; *Lancet*, Nov. 16, 1878.

Professor E. LANG (Ueber eine seltene Form der Parasitären ykosis und Seinige entzündliche Geschwülste, *Viertelj. für Dermatol.*

*u. Syph.*, 1878, p. 393) found, contrary to the experience of Thin and Taylor, budding spores abundantly in the root-sheaths. Lang also—most properly—draws attention to the inadequacy of the microscopic evidence upon which some writers are content to rest the diagnosis of fungous invasion of the hair and skin. He indicates figures 78, 79, and 80 of Fox's work ("Skin Diseases," London, 1873) as examples.

**The botanical relations of trichophyton tonsurans.**—A synopsis of this paper has already appeared in the ARCHIVES as part of the proceedings of the second annual meeting of the American Dermatological Association. Dr. ATKINSON's results from cell-cultivations have convinced him that the Trichophyton tonsurans belongs to the Mucors.—*N. Y. Med. Journ.*, December, 1878.

**Ringworm in public institutions.**—In a charitable institution containing 100 children, Dr. SHOEMAKER detected 49 cases of ringworm. Of these, 32 were boys, 17 were girls. Some portion of the head was involved in each of 41 of these children; in 5, the entire body; in 1, the arms and chest; in 1, the chest and back; and in 1, the scalp and face. Dr. Shoemaker succeeded in successfully inoculating two cats with the fungus, and from these, re-inoculations were practised with similar success upon two children.—Reprint from *Transactions of the Am. Med. Association*, 1878.

**"Tinea imbricata."**—Dr. SIEGFRIED, U.S.N., describes a skin eruption prevalent at Foochow, China, under the foregoing title, suggested by Dr. Manson: "It may be distinguished from tinea circinata by its invading all parts of the body gradually in a series of concentric rings, no part healing in its track; by its appearance, similar to that of a piece of watered silk; by its obstinacy; by the fact that it is usually from India or the Straits settlements; and by the microscopic appearance. The spores are more numerous and clustered than in tinea circinata; the mycelia are rarely or never twisted into ropes, but spread uniformly over the field, and the scales are larger. The epidermis is excavated and raised in flakes, and the fungus confines itself to the more superficial layers of the corium" (!). [Such reasons will have to be supplemented by much more cogent ones before the "new tinea" can be admitted.—REP.]—"Elephantiasis, Leprosy, and Tinea Imbricata;" *Phila. Med. Times*, March 1, 1879.

**A new fungus.**—VIDAL (*Présence d'un nouveau parasite dans certaines formes de pityriasis rosé*) considers that Hebra has confounded, in his description of eczema marginatum, cases of tinea versicolor, of tinea circinata, and cases described by Bazin and Gibert as pityriasis rosé. This latter affection may be also parasitic. In three cases Vidal discovered in the most superficial scales at the periphery of the patches very minute spores, from one to three micromillimetres in diameter, united into little rounded groups, and invading the epidermic cells. There were also found some

chains of spores, but no mycelium. In the discussion M. Cornil declared the fungus to be a common parasite, discoverable in all, even perfectly healthy desquamated epidermis. Malassez agreed with Vidal, and believed the fungus to be analogous with that described by himself in pityriasis capitis.—*Soc. de Biologie*, 4 Jan., 1879; *Gaz. Hebdom.*, 10 Jan., 1879, p. 27.

**On the etiology of area celsi.**—BUCHNER insists upon the parasitic nature of this affection. He claims to have made repeated successful cultivation experiments, the result being invariably the development of the same fungus. This has well-marked characters of schizomycetes, and consists of small, bright, sharply-contoured bodies, .001 mm. in diameter, with very thin and short prolongations extending in opposite directions. It resembles undeveloped "milzbrand" fungus.—*Kritische Bemerkungen zur Aetiologie der Area Celsi*; *Virchow's Archiv.*, lxxiv., 5, 527; *Centralbl. f. d. Med. Wis.*, 1879, p. 300.

**The origin of molluscum sebaceum.**—BOELINGER's paper contains his conclusions concerning the identity of the peculiar corpuscles found in fowls suffering from a singular epidemic contagious disease (described by him in *Virchow's Arch.*, Band 58), with the well-known bodies found in molluscum sebaceum of the human skin. Boelinger considers these bodies, both in man and in the fowl, to be simply gregarinæ, whose reproduction and development occurs by budding. The earlier developmental stages can be readily followed in cultivations. Later the formation of nuclei with nucleoli, as well as of an external cell membrane, can be easily noted. The affection, trivial in man, becomes in fowls a very serious disease, often causing speedy death, especially where, by the invasion of the buccal cavity, the throat and larynx, diphtheritic inflammation is produced. The anatomical conditions of the new formations, and the morphological peculiarities of the parasite, convince the author of the identity of the affections. From facts lately observed, Boelinger is inclined to regard the gregarinæ of rabbits as the probable starting point of the disease. He regards its transmission from fowls to the human subject as highly probable.—*Ueber die Ursache des Molluscum Contagiosum*, *Tagebl.*, d. 51, *Versammlung deutscher Naturforscher u. Aerzte* in Cassel, 1878; *Viertelj. f. Derm. u. Syph.*, 1879, 1 H., p. 151.

**Piedra.**—DESENNE has reported a parasitic disease of the hair occurring among the inhabitants of a certain part of Columbia. It is known as "piedra." It is characterized by the appearance of nodosities along the shaft of the hair, visible to the naked eye, as hard as a stone, even resisting the edge of the scalpel. It is not contagious, and disappears after innction with fatty substances. Microscopically, each node is seen to consist of regular accumulations of cells, traversed by black fibres. Surrounding the node is a fine network of branching mycelium, which embraces the hair-

shaft, stretches over the nodes like swollen protuberances, and consists, possibly, of the mycelium of the cryptogam forming the nodosity.—*Bulletin de Thérapie*, July, 1878; *Viertelj. f. Dermat. u. Syph.*, Heft 1, 1879, p. 151.

W. B. CHEADLE and MALCOM MORRIS, in an article entitled “Piedra, Trichorexis nodosa, Tinea nodosa,” describe an affection met with by them upon the moustache hairs of a young man. It was confined to the beard. The hairs were “thickened” and rough with some incrustating material, and here and there nodular swellings. Numbers of them were broken off short, and the shafts could be seen to be split longitudinally for some distance from the free end, where the fibrils separated in a brush-like manner. The disease did not affect the hair-follicle or skin. The incrustations, of granular-looking material as seen by a low magnifying power, were found, with higher powers, to present the characters of spores of a vegetable parasite. None could be detected within the hair-shaft until the splitting process was advanced; then, however, a few spores could be found in the interstices. These hairs were quite different from specimens of Trichorexis nodosa examined by the authors, who propose the term “Tinea nodosa” for the disorder. They consider it a very different affection from “Piedra.”—*Lancet*, Feb. 8, 1879, p. 190.

Mr. MALCOM MORRIS exhibited before the London Pathological Society, March 18, 1879, microscopical specimens and drawings of hairs from patients affected with “Piedra.” The disorder was stated to be always limited to the hair of the head, principally in women, and begins a half-inch from the root of the hair. It consists of from one to ten nodosities to each hair implicated. These nodes are hard and gritty. The disease is not contagious; the nodosities consist of a “honeycombed” mass of pigmented spore-like bodies, the whole mass arising from one cell, which buds radially in all directions. The growth is upon and not within the hair, and is supposed to arise from the use of a peculiar mucilaginous oil as a hair-dressing.—*Med. Times and Gaz.*, Lond., i. 409, 1879; *Lancet*, Lond., March 22, 1879.

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## II.

## SYPHILIS AND VENEREAL DISEASES.

GENERAL QUESTIONS IN SYPHILIS, THERAPEUTICS,  
ETC.

E. L. KEYES, M.D.

**Syphilitic inoculation by a tooth-brush; syphilis communicated by means of the saliva.**—The cases reported by BAXTER and BÖTRGER furnish fresh illustrations of the endless variety of methods by which syphilis may creep in upon the innocent and unwary victim. The possibility of infection by saliva containing the secretion from some secondary lesion within the mouth has long since been proved and is generally accepted. No new cases are necessary to establish this fact, but the value of new cases is undoubtedly, in that they serve to impress a given fact still more forcibly upon the community.

It is unfortunate, therefore, in reporting cases of this sort, that more care is not given to show that the syphilis in the patient could not have been derived from any source other than the one to which it is ascribed by the observer. In the patients of Baxter and Böttger this has not been done, and the cases, therefore, lose much of their force.

Thus, Baxter finds a three-year-old boy with a recent papular syphilide upon the trunk. The tonsils are swollen, and a superficial circular erosion is seen upon the tongue. The doctor finds also a large gland of stony hardness under the left side of the lower jaw, and learns that the child sucked his father's tooth-brush six or seven

weeks previously. He ascertains also that the father was suffering from an ulcerated mouth at the time, and discovers an early general syphilitic upon the trunk of the mother.

No chancre is found upon the gum or in the mouth of the child, and the avenue for the entrance of the infection into the mother is not inquired about. It appears strange to one familiar with the ordinary length of the periods of the first and second incubation of syphilis, that the poison applied upon a tooth-brush six or seven weeks before the date of a given eruption could have produced a chancre, which got entirely well and left no trace of its existence beyond the characteristic hardness of the submaxillary gland, in so short a time (perhaps four weeks after its first appearance); and although this is perfectly possible, is it not more probable that a baby three years old, both of whose parents seem to be syphilitic, might have been poisoned in a variety of other ways?

The looseness of Böttger's report is still more striking. He states that both parents are healthy, and that the child, nine years old, is well excepting for a double iritis, which had lasted several weeks, attended by adhesions and a troubled cornea on both sides. In seeking a cause for this iritis he looks up a servant who has had charge of the child, and finds that the bridge of her nose has fallen in, and that she acknowledges sexual contact at eighteen years of age, followed by a discharge from the vagina and afterwards by an eruption at the anus. He learns also that this woman has frequently chewed the food which she was giving the child and then put it into the child's mouth; and thus infection is accounted for. This is all well and good, but no mention is made of chancre, and the fact that the child gets perforation of the hard palate during treatment, with loss of several pieces of bone, is only considered worthy of a passing notice. Moreover, although it is implied that the servant became syphilitic at the age of eighteen, her age and the stage of the disease at the moment of the alleged infection of the child are not mentioned. Certainly in this case a critical study of the history and physical condition of both of the child's parents would have added largely to the value of the case, so far as demonstrating that the syphilis was acquired and not inherited is concerned.—*Lancet*, May 31, 1879, and *Memorabilien*, Jahr. 23, Heft ii., p. 63.

**Morphology of the blood in syphilis.**—E. CUTTER (of Boston) delivered on January 7, 1878, before the American Medical Association, a lecture on the morphology of the blood in syphilis, with stereoscopic and photographic demonstrations. He believes that in syphilitic blood the white cells are larger than normal, that mycelium threads and bacteria abound, coppery in color, and white blood-cells full of spores, which escape by a rupture of the wall of the cell.

Cutter found similar vegetable elements in the blood in erysipelas, diphtheria, and other maladies, but in these latter the coppery color of the spores, etc., is absent.

Whether this discovery is to quietly disappear like those of Salisbury and Lostorfer a little time will show. Along with the helikomonads of Klebs, it must stand the test of observation by other investigators.—*Transactions Amer. Med. Assoc.*, 1878, p. 165.

**Syphilis as an imitator.**—HUTCHINSON believes of syphilis as Tupper of Satan, that it can mar, not make. He believes that all the lesions of syphilis might be produced by other causes. He likens roseola to measles, speaks of syphilitic psoriasis and lichen, and dilates upon the variolous syphilide and the symptoms produced through the eye and brain by syphilitic lesions.

[It seems unfortunate to strip syphilis of any of its individuality. Syphilitic epilepsy is certainly a distinct disease, and not an imitation. Is it fair to speak of phthisis of the lung as an imitator of a crumb of bread in the larynx because both produce cough?—REP.]—*British Medical Journal*, April 5, 1879, p. 499.

**Irritation and syphilis.**—KOEBNER, after discussing Tarnowsky's statements regarding his (Koebner's) views about the virus of syphilis and the product of chancroid, etc., records that he has employed Tarnowsky's (revival of Meggenhofen's) "cauterisatio provocatoria" upon ten syphilitic patients, belonging to the later as well as to the earlier periods of the disease. In two of the latter the cauterisatio provocatoria was performed before any mercurial treatment had been given. In not a single instance did he obtain the positive results such as they are described by Tarnowsky.

In spite of this negative result, four of his patients had already had relapses of syphilis at the date of writing the article.—*Vierteljahresschrift für Dermatologie und Syphilis*, Heft iv., 1878, p. 589.

**Syphilis in the negro.**—POWELL states that he has been unable to find anything in print relative to the differences assumed by the symptoms of syphilis in the black as compared with the white people of this country.

He then reads from the book of nature that syphilis is very much milder in the negro than in the white; that secondary symptoms are infrequent, and tertiary symptoms rarely occur in the negro, while the results of treatment are more permanent and satisfactory than in the white.

After reaching this pleasing conclusion, a case of the purest kind of chancroid, furnished by Dr. Ringgold, of Grenada, is detailed as a case of syphilis, and the startling announcement made that in four or five weeks the patient reported himself perfectly well, although he had taken no constitutional remedy, and had only been treated by the use of slippery-elm poultices to the suppurating buboes and red-oak ooze to the chancre.

The doctor finds no difficulty in the unity and duality question in syphilis. He is satisfied that syphilis imparted from white to white continues syphilis, from white to negro it becomes chancroid, *et voila tout.*

[It is to be hoped that the Mississippi State Medical Association duly appreciated the value of these decidedly original views.—REP.]  
—*Transactions of the Mississippi State Med. Assoc.*, 1878.

**Treatment of unhealthy local and syphilitic sores by immersion.**—COOPER's short article abounds in interest. He disclaims any novelty in the use of immersion for the cure of unhealthy local and syphilitic sores, referring to what has been already done in the same direction by Hebra, Hutchinson, Hémard, and others. The results of the treatment as reported are so exceptionally good that the method employed deserves detail. Mr. Arthur Cooper was a house-surgeon in the Lock Hospital, and the cases he speaks of were treated there under the direction of Mr. Alfred Cooper and of Mr. Milner.

The patient sits in a hip or other bath with the affected part entirely submerged during eight or ten hours a day. The temperature of the water is maintained as near 98° as possible. A blanket protects the shoulders from cold. A blanket or an air-cushion rests between the patient's back and buttocks and the tub. In the evening finely powdered iodoform or other dressing is applied, and with this dressing still upon the sore the patient enters the bath upon the following day. The dressing in this way falls off without pain.

A purge before the course of baths, tonics and appropriate internal treatment during their use, and a continuance of the process until a healthy action has become thoroughly established in the sore, constitute the method.

Thirty-one cases are referred to. Twenty-two of these were phagedenic or sloughing sores of the penis, which had lasted from a few days to several weeks; the others were various forms of phagedenic, tertiary, syphilitic, and gangrenous lesions involving the penis, scrotum, groins, and thighs. In no case was the bath used longer than twelve days. In most of the cases the ulcer became healthy in from two to six days.

The following case is given: A healthy-looking man of 21 gets chancroid on the penis and suppurating bubo. Both of these lesions are attacked by sloughing phagedena, extending "so rapidly that in a few days the cavity in the man's groin had the diameter of one's fist." Four days of submersion arrested the spread of the phagedena. The baths were continued for eight days longer. "Both chancre and bubo then rapidly healed."

Three cases of "slowly spreading non-inflammatory form of phagedena" relapsed after the bath was discontinued; due perhaps, the writer states, to too short a continuance of the submersion.

There were three failures. The first was that of a large sloughing primary sore in a case of malignant syphilis, "the patient being at the same time almost covered with an ulcerating syphilide. After nine days of the bath he refused to continue it." Case two was too stout to sit comfortably in the bath. In case three the bath aggravated the pain of an extensive tertiary ulcer; generally the bath relieves pain.

An unsuccessful case has been reported by Coulson and another by Hutchinson.

If the sore lies beneath the prepuce, it is better to remove the latter by circumcision. The wound, it is said, "scarcely ever takes on the diseased action." The bath should always be continued for at least a day after the diseased surface has become quite healthy, and continuous immersion by night as well as by day should be tried (Hutchinson) when intermittent immersion fails. This method is worthy of extensive trial, in hospitals at least.—*Lancet*, May 24, 1879, p. 731.

**On the uses and applications of iodoform.**—COTTLE has employed iodoform internally, as recommended by Mr. Hill and Dr. Prosser James, in late syphilitic ulcer of the tongue and for nasopharyngeal affections, and has been disappointed, finding iodism common, and no specially good effect from grain and grain and a half doses.

Externally employed Cottle thinks highly of iodoform, mentioning among other qualities its virtues as a parasiticide. Being an irritant, Cottle thinks iodoform only applicable to ulcers after they have become indolent, never during any acutely inflammatory stage. He finds also that iodoform is apt to inflame the sound skin around a lesion, if kept in contact with it for any length of time.

The different methods of applying iodoform are detailed, its mixture with tannin and Fuller's earth to moderate its action, the use of essential oils to cover its disagreeable odor.—*Lancet*, January 18, 1879, p. 82.

**Syphilitic chancre communicated by a whistle.**—GROSS's buccal chancre (4), encountered at the Saint-Léon Hospital, was acquired by a railway guard from a whistle which he borrowed from another guard and used in place of his own.—*Rev. Méd. de l'Est.*, March 1, 1879; *Lyon Méd.*, April 6, 1879, p. 511.

**Excision of chancres.**—KÖLLIKER, following Auspitz, reports eight cases of excision of chancre, with what he is pleased to consider success in three cases in aborting the disease,—*i.e.*, preventing secondary symptoms of syphilis. In five cases syphilis followed in spite of the excision, and it will cease to appear wonderful that syphilis remained absent in the other three when it is observed upon close inspection that in successful (?) case No. 1, nothing is known about the date of infection, the length of incubation, or the source of the sore; there were no enlarged glands anywhere. In successful case No. 2, *although the sore had lasted two weeks*, still there was no glandular engorgement; surely a gentle chancre. In successful case No. 3, the only successful case in which any gland was involved, nothing is said about confrontation, and we are informed that there was *a* (!) bubo in the right groin.

[The reports our German friends have thus far furnished us with prove nothing, unless it be claimed that they still further exemplify

the danger of attempting to make a positive diagnosis of syphilis from the physical characters of the primary lesion alone.—REP.]—*Hospital Gazette*, March 18, 1879, p. 9.

**Syphilis of the lung.**—SACHARJIN's conclusions as reported by Pavlinoff are, that—

(1) Syphilitic pneumonia is apt to be accompanied (complicated) by active bronchitis and adhesive pleurisy as well as by chronic (phthisical) pneumonia, and towards the end of life by acute pneumonia of the lower lobes.

(2) If the syphilitic pneumonia be complicated by bronchitis, phthisical pneumonia, etc., the complications should be treated according to their symptoms, and the syphilitic malady not be attacked until the complications have been removed.

As for the relative value of mercury and iodine, S. thinks that each case is its own standard. The longer iodine has been used and the less powerfully it has influenced the patient the more hope is there from mercury, etc.—*Archiv f. Path. Anat. u. Phys. u. f. Klin. Med.*, Bd. 75, Heft 1, p. 162.

**Pilocarpin in syphilis.**—LOCKWOOD, getting the idea from Zittman's decoction, determined to try pilocarpin in the treatment of syphilis. He gives two cases, one of which had a scaly tubercular syphilitide, with mouth lesions. The chancre persisting, one-sixth of a grain of nitrate of pilocarpin was administered hypodermically every other day for two weeks. No mercury was used. The sore got well, as did the rash. The throat remained sore, and the patient ceased to attend as an out-patient.

The other case was one of extensive rupia, with mouth lesions and double iritis. For fifteen days he gave mixed treatment without improvement, then calomel vapor-baths for thirteen days in vain. Now the strength of the calomel-bath was reduced from fifteen grains to five, and one-sixth of a grain of nitrate of pilocarpin given hypodermically every other day before the bath.

Sweating, absent in the bath before, now became profuse, and continued for nine hours (7 P.M. to 4 A.M., "wetting his bed-clothes through and through"). Improvement began at once, and after thirty-three days—fifteen baths—the crusts had fallen, he was practically well, and, desiring his discharge, left the hospital.

**Treatment of syphilis.**—SIGMUND thinks that during the first six to eight weeks local treatment alone is required for the local expressions of syphilis. He goes even so far as to say that general treatment in some cases does harm. He believes that forty per cent. of cases untreated have such light secondary symptoms that the patient does not detect them, and that ten per cent. of those having obvious general symptoms get promptly well by the employment of local measures alone.

He thinks, therefore, that general anti-syphilitic treatment should only be commenced in the secondary stage, and only in those cases

which seem to be seriously threatened with dangerous symptoms, involving several systems and organs. Careful hygiene, dietetics, and local treatment meet the requirements of most cases.

[Since the disease is so simple and easy to manage, it is difficult to refrain from wondering what, if any, percentage of the so-called syphilitic cases were examples of chancroid or of pseudo-chancrore of syphilites.—REP.]—*Wien. Med. Woch.*, 1879, No. 10; *Deutsch. Med. Woch.*, No. 14, 1879, p. 173.

**Denis-Dumont on syphilis.**—These lectures handle three most important questions in syphilis: (1) The unity or origin of syphilis; (2) its incurability; (3) its treatment. The first head is disposed of in five lectures. Three lectures are devoted to incurability, and the rest have not yet come to hand.

The five lectures upon the question of the unity of the syphilitic virus treat the subject historically as well as clinically and take the beaten path, discussing gonorrhœa, chancroid, and chancre. The author concludes that all three are virulent, and that each is totally distinct from the other. He believes also that syphilis was brought to Europe by the ships of Columbus from America.

The latter historical question is of little importance; but discussions upon the unity or duality of syphilis are still of value, since authorities differ upon this point. Practically, the question is settled that chancroid and its results differs from chancre and its results as white from black, but, theoretically, the medical world is still befogged in the matter, and it is only by constant contention that actual truth will finally be reached. Therefore the greater the fervor of the contest the sooner will it terminate. The present articles on historical and clinical grounds sustain the virulence of chancroid, but separate it entirely from syphilis.

In the two lectures on the incurability of syphilis, Dumont advocates the general acknowledgment by the profession that syphilis is incurable, on the ground of general utility. "For," he says, "is not hydrophobia generally acknowledged to be incurable, and on that account do not men avoid a dog known to be mad, and also avoid many other dogs only suspected of being mad? How gratifying if the same result could be attained in regard to syphilis! But, alas! . . . in this case the dog is only believed to be mad after he (she) has bitten, and sometimes not even then."

Dumont sustains his assertion of the incurability of syphilis by some excellent personal cases, in three of which the disease remained latent for twenty-nine, forty-four, and fifty-five years respectively (although the fifty-five year case cannot pass without some question), and in two others continued active, requiring treatment after thirty-eight and twenty-seven years.

He disposes of the proof of the cure of syphilis furnished by second attacks of the disease in the same person, on the ground that it is so phenomenally exceptional as not to amount to anything. Four-nier, he says, has never seen a case, nor has he. He thinks mixed

chancroid inoculated as chancroid may account for some supposed cases. More lectures are to follow.—*L'Année Med.*, August, September, October, and December, 1878; February, April, May, and June, 1879.

**Expectant treatment of syphilis.**—ZEISSL states that he writes this series of articles in response to a number of questions which have been addressed to him, verbally as well as through the press, asking why he has so materially altered his views concerning the therapeutics of syphilis of late years, and what his present ideas upon the subject are.

He speaks of having grown up in medicine with Hebra, Skoda, Rokitansky, Dietel, and witnessed their struggles against hypermedication in disease, notably Dietel's successful treatment of pneumonia, typhus, etc., by pure expectation.

This determined Zeissl to try expectation in the treatment of syphilis when he had a good opportunity. Up to 1864, when he published his "*Lehrbuch*," this opportunity had not arrived, therefore in this book he adhered to the classical methods with which he had long been familiar, mainly in the hands of others.

In 1869, in the K. K. Allg. Krankenhaus, a second division and clinique for syphilis was established and given to Zeissl, thus furnishing him an in- and out-service with twelve hundred and fifty subjects, of which four hundred and fifty to five hundred were syphilitic.

Here was the long-wished-for opportunity, and Zeissl immediately commenced to improve it. He selected from his patients who had the initial lesion of syphilis a number having as nearly as possible similar constitutions, put them on regular diet, treated the chancre with lime-water, carbolic acid solutions, and the like, and waited for secondary symptoms.

When general symptoms appeared the patients were divided into three classes. One lot got mercurial frictions, another preparations of iodine, the third purely indifferent preparations, to satisfy their minds that something was being done.

He now observed that in many cases ten to fourteen frictions promptly dissipated the symptoms, while in other cases the symptoms remained considerably longer, in spite of the frictions. He noticed that the internal use of the preparations of iodine was followed by a disappearance of the symptoms often within two weeks, but that many cases required four to eight weeks, and others a longer time for involution.

In the cases treated by expectation he found that the secondary outbreak disappeared in from four weeks to several months, while in two cases a syphilitic exanthem disappeared entirely in fourteen days without any treatment.

In this way Zeissl learned that syphilis was atypical, seeming to depend for its course largely upon the physical individuality of the patient, the symptoms being short or long in duration, light or severe in type in different cases, irrespective of treatment. He noticed

that gummatous forms of syphilis appeared as well in the cases treated by expectation as by other methods, but, he thinks, much less often than in the cases previously treated by mercury or the preparations of iodine. He noticed, also, that after a mercurial treatment relapses were more frequent and, as a rule, more obstinate than after treatment by expectation or by the preparations of iodine. He noticed that when treatment by iodine or expectation did not cause the early symptoms to disappear in four weeks, a few inunctions (ten to twelve) with mercurial ointment caused the symptoms to cease.

Zeissl states that if the first eruption be allowed to disappear without the aid of medicines and no other symptoms come on for one year, the patient may be considered to be well.

The expectative treatment requires patience, all the eruptions requiring considerable time to disappear, but Zeissl considers that by this treatment, with appropriate diet, cure is possible.

Zeissl here parenthetically remarks that he is not an anti-mercurialist; on the contrary, he thinks that the preparations of mercury are of great value, and in many cases of syphilis indispensable. He shelters his conclusions behind the clinical observation of forty thousand syphilitic patients encountered during an observation lasting over many years.

Of one hundred patients treated for the first eruption with mercury, Zeissl says that ninety-six will have relapses. He thinks that the early syphilitic headache disappears most promptly under three to four frictions of mercurial ointment, 3ss each. He believes that early syphilitic symptoms disappear most quickly, as a rule, under subcutaneous injections of calomel, but condemns the method on account of the painful inflammatory exudations which occur at the points of puncture.

Zeissl's ground is that mercury is not a bad agent, but that its early use is bad. He believes that syphilis should have a given time to blossom and ripen as it were, two or three months, and that then the mercury should be used in great moderation,—ten to twelve frictions or injections. He does not use mercury at all until the expectative methods and that by the preparations of iodine have failed to give satisfaction; and he believes that in this way he obtains the greatest good for his patients, the quickest as well as the most lasting cures.

When no treatment is used the eruptions cease to appear on an average in from two to eight months. Defluvium capillorum and glandular engorgement lasts often a year. Relapses, especially of a severe character, have been observed very seldom by Zeissl after an expectative treatment.

Although Zeissl believes the expectative method the best, still he rarely practises it; in hospitals, because the patients must get cured of their symptoms and go to work again, in private, because patients are unwilling to let their symptoms work themselves out, but demand a quick relief.

Consequently the method followed in the clinique is iodoform or

indifferent local applications to the chancre. When the first eruption appears,

R.—Tinct. iodinii, 2.00;

Aquæ dest., 200.00.

Tablespoonful night and morning.

If this causes cardialgia, he gives

R.—Potass. iodid., 10.00,

vel natrii iodid.,

Pulv. et extr. gentianæ,  $\frac{aa}{aa}$  q. s.,

ut fiant pil. No. 100.

8-12 morning and evening.

Iron is given (iodide of iron) to anæmic patients in solution in a dark syrup to prevent decomposition by the light, or in pill form.

If the syphilitic exanthem resists this treatment for six weeks, then he employs mercurials in injection, friction, or internally, being very careful that the patient keeps the skin and mouth in good order.

Much detail follows about the use of frictions and injections, and their results. The only preparation he uses by the stomach is the following :

R.—Calomelanos, 0.15 ;

Extr. belladonnæ, 0.07 ;

Sacchar. alb., 3 00.

Div. in dosis æqu. No. 8.

One powder to be taken four times a day.

Mercurial fumigation and mercurial suppositories he has not used at all for many years.

Zeissl has employed tayuga in fifty cases, but has not made up his mind about it except that he has decided that it can do no harm in health or disease. The appetite improves under it.

Diday is quoted in support of the author's views.

In brief, it seems that Diday and Zeissl think alike, and Sigmund seems to join them, that chancre and the light early eruptions should be treated by expectation without specifics. Next, that harder cases require preparations of iodine, and finally, only severe ones and those not yielding after a fair trial of the other methods demand mercury.

In short, nearly all the world at the present day seems to be coming to a belief that mercury is very powerful and must be sparingly used, either for only a short time in reasonably large quantity in hard cases, or for a long time in minute doses, either continuously or intermittently as others believe.—*Wiener Med. Wochens.*, 1879, Nos. 1, 2, 3, 4.

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## REVIEWS AND BOOK NOTICES.

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*Lectures on Dermatology.* Delivered in the Royal College of Surgeons of England, in 1876, 1877, and 1878, by Erasmus Wilson, F.R.S., F.R.C.S. London, J. & A. Churchill, 1878. Pp. 286.

We have read this volume through with great interest, and, while there is considerable in it from which we must withhold assent, we cannot but feel its value as the latest and possibly the last addition to dermatology of one who has given his life work to it, and whose large clinical experience, derived almost if not quite wholly from private practice, furnishes much that is valuable to others.

The present and last volume of these lectures treats of derangements of color of the skin, affections of the nails, hair system, and cutaneous gland system, and is written in Mr. Wilson's pleasantest style. This volume, however, contains, we judge, manifold more curious and otherwise unknown words indicative of disease than any other medical work of its size extant. It would be almost impossible as well as useless to detail them all, but we cannot help recording a few which we noted when reading, such as Acmai for acne, Trichodyscroia, Phalangosis ciliorum, Clastothrix, Trichoclasia, Sclerothrix, Atmoothrix, Lepothrix, Trichonotic diathesis, Leucasmus, Dyschroma, Ophiasis, etc.

Mr. Wilson still adheres to the non-parasitic nature of what are commonly accepted as the vegetable parasitic diseases,—favus, ring-worm, and tinea versicolor. He recognizes, microscopically, the elements which others regard as fungus, but calls them *phytiform* degeneration of the cells of the epidermis and hairs. Says he, "After as long an experience of the pathology and diseases of the skin as any man at present living, I am an utter disbeliever in this simple and attractive theory of fungus vegetation and degeneration." He considers that the matter may be reduced to the following terms: "chronic folliculitis, by altering the nutrition of its epithelium, has a natural tendency to give rise to a *phytiform* metamorphosis of its cell-elements, and to develop those forms of organic growth which have been termed a parasitic fungus."

We would like to ask Mr. Wilson if he believes that matter after leaving the human body can take on the phenomena of life? If not, how does he explain the growth of these *phytiform* elements found in the three vegetable parasitic diseases, when, upon the slide of a microscope, they may be watched in their development from day to day, as we and others have watched them, until the

entire field is covered with a luxuriant growth of branched mycelium, starting from these same *phytiform* elements within a hair taken from tinea trichophytina, or tinea favosa, or from the scales of tinea versicolor? The subject has passed beyond the stage of individual opinion to a demonstrated fact in science, that vegetable fungus certainly can and does grow and fructify on the human frame, and that the *phytiform* elements are true, living, vegetable organisms, and not altered epithelium cells. Whether the diseases in which they are found are produced by this growth is another matter, about which, however, there is little doubt in our mind or in that of a large majority of dermatologists. The proofs of this are found in the actual production by artificial inoculation of the diseases in question, although, as is well known, only a very small share of the experiments in this line succeed, for the reason that there is lacking the proper soil or conditions of the system for the growth. This latter assertion cannot be construed into begging the question, for it must be granted that all vegetable organisms require their proper conditions, soil, and climate. Cotton and the Southern moss cannot luxuriate in the cold North, nor many Northern plants grow in the South. Again, not even Mr. Wilson denies the parasitic nature of scabies or phthiriasis, and yet how many are exposed to them without acquiring the disease.

Mr. Wilson bases his argument in part upon his own statement (page 61) that favus may be declared to be utterly non-contagious in England. If that is true in regard to England, it certainly is not the fact in other countries. We can point to several series of cases occurring in New York City where there was no doubt in regard to contagion. He also states that "ringworm, which is the most contagious of all the three afflictions, is contagious only in a mitigated degree." We beg to differ in regard to the latter part of the sentence, and can adduce many, many cases of its occurrence in families, and can recall hardly a single instance of an isolated case. We can also introduce Mr. Wilson to two asylums in which the disease is rife, and in which it resists greatly prolonged and active efforts at its expulsion.

Candidly, we cannot possibly see the force of our author's reasoning, and cannot yield that he at all proves his case; in such a matter mere *individual* opinion cannot decide a point where scientific facts decide contrariwise. We cannot help expressing the strongest desire that Mr. Wilson should thoroughly study the matter anew in company with some competent microscopist (other than Mr. Jabez Hogg), making some of the *culture* experiments of Neumann and others, and that he should again duly consider the clinical evidence afforded by other observers, and cannot believe but that he would thus be convinced of the untenability of his present views. It would be desirable for dermatology that he should publicly accept what is now considered to be demonstrated in this matter, for the influence of his writings is undoubtedly widely extended, and many and gross errors might result if all that is stated in the book be-

fore us in regard to the non-parasitic nature of these diseases were acted upon.

On the other hand, too much cannot be said in favor of the enlarged views inculcated in regard to the general relations of skin diseases and their dependence upon systemic depression and derangement. The expression "nutritive debility" is of very frequent occurrence, and sometimes appears overdrawn, but in the main the effect is good, as it directs attention to the constitutional causes of skin diseases, without a recognition of which very little true and lasting benefit can be obtained in them.

When closely criticised, some points appear ludicrous; thus, in speaking of the treatment of freckles, after enumerating other measures, he advises certain internal measures, ending thus, "and above all, the queen of nutritive tonics,—arsenical solution." Again, arsenic is recommended in the treatment of excessive hairiness on the face, while in the treatment of exactly the reverse condition, namely, alopecia, he says that "arsenic bears the palm."

The volume closes with Mr. Wilson's farewell to the chair of Dermatology in the Royal College of Surgeons of England, he having in the nine courses of lectures gone over the entire subject and accomplished the task he had set himself at the beginning. He uses words which it would be wise for every dermatologist as well as physician to bear well in mind. "I have always endeavored," says he, "to keep in my mind that dermatology is a branch of general medicine to be practised by all its practitioners, and, therefore, that it ought to be assimilated as completely as possible with the two great branches of practical medicine,—that of the physician and that of the surgeon. . . . I have taught that there is nothing special in the structure and pathology of the skin, and consequently that there should be nothing special in its practice beyond that which results naturally from familiarity and experience of the subject."

*Leprosy is Contagious (La Lèpre est Contagieuse), with a Colored Chart of the Geographical Distribution of Leprosy.* By a Missionary attached to the Leper Hospitals of Trinidad. Paris: J. B. Ballière et Fils, 1879. Octavo. Pp. 286.

The assertion which forms the striking title of this book should command for it more than the passing notice of a book review; it should engage the attention not only of the dermatologist, but also of the general physician, of the sanitarian, and the philanthropist.

And the subject should not be dropped with a brief consideration of the author's views; but as he has written carefully and conscientiously, and to the length of nearly three hundred pages, and as he, moreover, refers very largely to the accepted literature of the subject, his argument and facts are worthy of careful consideration, although they are not presented by one already known to fame, and although indeed the name of the writer is entirely, although unwisely, withheld. If leprosy is contagious, the profession and the world

should know it ; if it is not, the fact should be proven beyond a shadow of a doubt.

Our author is not a medical man, although we might judge that he was from the knowledge shown not only of the literature of the subject, but also of medical terms and facts, and from his method of treating them. He has, however, been for ten years a resident in a large and excellent leper hospital, full of patients, and has given much time to the study of the disease, and has been placed in relations with very many of the countries where leprosy has existed.

He first states that by leprosy he intends the true disease, the elephantiasis Græcorum ; and the pages of the book show that there is no mistake in the disease, and that his experience in the leper hospitals has made him familiar with the malady.

In order that his position may be perfectly understood, he then goes on to recount the steps inaugurated by the British government in 1862, when, at its request, the Royal College of Physicians in London drew up the plan for the general investigation of leprosy throughout the colonies, and the special inquiry was made in regard to the contagiousness of the disease. He recounts the substance of the reports made by the committee who analyzed the returns, and quotes the words of several of the reports. Thus from the final report, in 1867, he extracts the following : "The almost unanimous conviction of the most skilled observers in different parts of the world is entirely opposed to the belief that leprosy is contagious, or communicable by proximity or contact with those affected. The proof derived from the experience of those employed in the leper hospitals is especially conclusive in this matter. The few cases which have been reported as contrary to this either rest on imperfect observation, or are given with so little attention to details as not to weaken this conclusion. That leprosy is rarely, if indeed it is ever, transmitted in sexual intercourse when but one of the parties have any tendency to the disease, is the opinion of a great majority of observers who have given it attention."

He further refers to Danielssen and Boeck, who deny the contagiousness of leprosy, and quotes likewise the opinions of Dr. Gavin Milroy, Van Dyke Carter, and others to the same effect.

But he claims that all this evidence is not conclusive, and his experience warrants him in an opinion quite contrary to that generally received. Says he, "On reading the very numerous responses made in answer to the inquiry of the British government, it is easy to see that the larger part were made by persons who had observed but little, and who had seen but few cases." He claims that reports favoring the contagiousness of the disease, which were well authenticated, were ignored by the Royal College of Physicians. He claims also that the matter of the asserted exemption of attendants upon leper patients was not true, and that the evidence of contagion from that source was great. He claims that more than one-half of the earth is leprous ; that where the strictest rules of separation have

been enforced, as in Curaçao and New Brunswick, the disease is checked; that Europeans in leprous countries do not acquire the disease except when they have been in contact with those affected. He asserts that in certain countries where it has been claimed that isolation of lepers exists, the rules of separation are not strict.

He asserts also that the statement in the Report of the Royal College of Physicians is not exactly true, when it says that "the almost unanimous conviction of the most skilled observers in different parts of the world is entirely opposed to the belief that leprosy is contagious," and claims that the list of contagionists is large, and cites the missionaries who have long had charge of large lazarettos in regions where the disease abounds; these, we judge, were not reached by the circular of the British government, which was sent to colonial and military and naval medical officers.

He further claims that the influence of heredity has been largely overrated; thus, infants become affected which are the children of Europeans or of those not who are free from the disease; or the child contracts it from the second husband of its mother; or it is affected before its father or mother acquire the disease; or, indeed, so far from receiving it from its parents, it gives it to them.

In regard to the effect of sexual intercourse, he holds that the opinion that the disease is not transmissible is founded upon very incomplete observation, for while certain cases escape, others certainly do become thus affected,—negative proof is valueless compared to positive.

As to the communication of the disease in social life, and especially in families, and in the case of those attending upon leprous patients, the book is full of instances, given in detail, which appear conclusive.

He concludes: "If we have had in the Sandwich Islands and French Guiana two striking examples of the multiplication of the disease by the facility of intercourse and contagion (and cohabitation), we have also in Curaçao and New Brunswick two remarkable examples of its almost complete cessation by isolation. Here spontaneous cases are absent, which demonstrates that the efficacy of the separation is due to the fact that the propagation of leprosy is entirely in its transmissibility, either by heredity (but heredity is but a partial factor) or by contagion (cohabitation or inoculation). It is because all propagation is in communication that this law is true, 'freedom of intercourse causes multiplication of the disease, and separation results in its extinction.'"

In regard to the element of contagion, the active agent in communicating the disease, our author believes that infection takes place through the agency of the respiratory passages, and asserts that the well-pronounced leper exhales an odor which marks his presence, and which not infrequently leads to his discovery, and often humiliation, as in travelling in public conveyances. He says that frequently priests, in the confessional, in administering extreme unction, etc., are profoundly affected by the effluvia coming from leper patients.

But he does not restrict it to this method, although in the various relations in which contact occurs the disease may be thus communicated.

The work closes with an account of leprosy as observed in the island of Trinidad. The earliest knowledge of the disease there was in 1805, when three persons were said to be the first victims,—one of these had come from a neighboring island. The population then was about 30,000; in 1813, with a population of 32,000, there were 73 lepers; and in 1878, when the population had reached 120,000, the number of lepers was 860,—that is, with less than four times the increase in population, the proportion of lepers had increased nearly eleven-fold; this is probably below the real figures, for, as is known, many patients with such affections escape the knowledge of the authorities.

Numerous tables in relation to sex, age, color, etc., are given which do not concern us here as bearing much upon the question of contagiousness.

Appended is a colored lithographic map of the world, which shows in a striking manner the very great extent of territory over which leprosy is found, and upon it are indicated the lines of travel, demonstrating the mode in which the disease is conveyed; and the dark-colored portions of the map, which we recognize as the portions which are known to have the disease to a greater or less extent, show that his assertion is true, that over more than one-half of the earth's surface the disease may be traced.

As remarked at the beginning, the statement that "leprosy is contagious," backed by such proof and argument as is contained in this book, should claim and secure for it more than a passing notice; the subject should be investigated anew, and either the decision of the Royal College of Surgeons of London or the conclusions of this author should be challenged and proved, or disproved, beyond a doubt, if such is at all possible.

1. *La Syphilis du Cerveau.* Par A. Fournier. *Leçons Cliniques recueillies par E. Brissaud.* Paris: G. Masson, 1879. Octavo. Pp. 649.

2. *The Brain and its diseases.* Part I. *Syphilis of the Brain and Spinal Cord, etc.* By Thomas Stretch Dowse, M.D., etc. London: Ballière, Tindall & Cox, 1879. Republished by G. P. Putnam's Sons, New York, 1879. Octavo, cloth. Pp. 142.

1. Notwithstanding the labors of Lancereaux, Heubner, Lagneau, and others, much remains to be said about this branch of syphilis. M. Fournier has come into the field, and certainly has done his share in making the clinical features of the disease much more clear than they have ever been. So obscure are the manifestations of this very common form of disorder that diagnosis is often difficult in the extreme, but the advantage of a systematic consideration and the exposition of practical knowledge derived from a long experience such as that of M. Fournier, must be of the greatest value to the

physician and patient in the matter not only of prognosis, but treatment as well. It therefore befits every practitioner and student of nervous diseases to keep fully abreast with the latest advances in syphilography.

M. Fournier's observations are of great interest, especially those in regard to etiology, which cover the ground quite fully. This part of the subject is considered *in extenso*, and our author's experience has been such as to enable him to speak authoritatively. He is disposed to fix the limit of the period during which nervous syphilis may appear, within the third and twentieth years after the primary sore, and he still further subdivides this period into two others, viz.: 1. Cases in which the nervous lesion arises between the third and tenth years; 2. Those beginning between the tenth and twentieth years. The majority of cases, however, come under the former division. The consideration of syphilitic disease of the mind is especially good, and the lectures are full and readable, while many hints are given which cannot fail in helping the medical man to properly distinguish the insanity which is curable and that which is not. We have read with more than ordinary interest M. Fournier's lectures upon epilepsy, and we know of no other literary effort so complete or valuable. It would be unnecessary to call especial attention to other features of the work, which should be read by every one interested in the subject, and we can only say that we consider it to be the best book upon the clinical features of the subject in any language.

2. We are sorry that we cannot as heartily recommend the other volume, for Dr. Dowse's previous efforts in neurology have been so marked by good honest work and thought. The volume before us is superficial, abounds in loosely-made statements, and contains very little that is new or original. The former is especially noticeable upon pages 14 and 15. We should like to know upon what authority Dr. Dowse says that "a vaso-motor paresis of the vessels of the kidney will produce *acute madness in the twinkling of an eye.*" This is a pathological and clinical assumption which is, to say the least, very doubtful. Such statements are made at various parts of the book, and detract greatly from its scientific value. The cases are well detailed, however, and as individual contributions to the literature of the subject are not without interest. Some excellent suggestions are given in regard to treatment. Our author does not believe in the possibility of an attack of syphilitic paraplegia after seven years, and his conclusions are based upon seventeen cases. This hardly agrees with the experience of some other observers.

The illustrations are for the most part poor, that on page 72 especially so, and numerous errors in composition, and the evidences of careless proof-reading, are apparent.

A. MC L. H.

*Pathology and Therapeutics of Skin Diseases, in Lectures for Physicians and Students (Pathologie und Therapie der Hautkrankheiten, in Vorlesungen, etc.).* By Dr. Moriz Kaposi, Professor of Dermatology and Syphilis in the Vienna University. First half. Vienna, 1879.

As is well known, Kaposi, who has been very intimately associated with Hebra for a number of years, wrote almost all of the second volume of Hebra's celebrated work, which was completed three years ago. The first volume appeared in 1860, and a second edition of it in 1874, not much altered.

Kaposi now writes in the form of lectures more or less clinical, and this first half of the work, comprising four hundred pages, extends to lichen ruber, in Hebra's classification. The whole will be about one-half the size of the larger work, and is designed to present the most recent views in cutaneous pathology and therapeutics more concisely than in Hebra's large work, and, as might be expected, reflects Hebra's views in every way.

One-quarter of the volume is taken up with general considerations, and of this thirty pages are given to the anatomy of the skin, with twelve illustrations, one of them being an excellent chromo-lithographic plate from Tomsa. The entire volume has twenty-three illustrations, seven of which are new, the others have figured elsewhere, as in Neumann, etc. We notice that no cuts are given of the pathological anatomy of psoriasis, nor any notice taken of the recent researches of Robinson, which have been abundantly confirmed by others. The new cuts are valuable additions to this department, and among them may be specially mentioned three illustrating herpes zoster, in which the author has made a number of studies. An illustration is given of the "molluscumkörperchen," the bodies which have given rise to so much discussion in molluscum contagiosum, but in this as in other figures no mention is made of the magnifying power used,—a serious error. Kaposi still regards molluscum as a sebaceous disease, and disbelieves in its contagion.

The Vienna school is certainly still very active in dermatological work, and even though all may not agree with Kaposi in his excessive exaltation of the share which Hebra has had to do with all dermatological progress in the present century, we must agree that more clearness and precision of thought have resulted from his labors in this field than from those of any other single teacher.

After a review of the history of dermatology and mention of many of the more prominent names connected therewith on the Continent and in England, in ancient and modern times, our author gives this recognition of American work: "While in *North America*, certainly during the last few years, but with an astonishing power of originality and fertility, dermatology flourishes, fostered by a considerable number of physicians, for the most part *pupils of the Vienna school*" (italics ours). He forgets that, with hardly an exception, these gentlemen have also studied largely in Paris, London; and

elsewhere, and that American dermatology combines the features of many countries.

*Photographic Illustrations of Skin Diseases.* By George Henry Fox, A.M., M.D., Clinical Professor of Dermatology, Starling Medical College, Columbus, Ohio, etc. Parts I. and II. E. B. Treat & Co., New York.

These two parts, illustrating Comedo, Acne vulgaris, Lepra tuberosa, Elephantiasis, Keloid, Rosacea, Psoriasis nummulata, and Ichthyosis simplex, are the first of a series of twelve, which will aim in the forty-eight plates to represent "nearly all of the rare as well as the common affections of the skin with photographic accuracy."

Numerous attempts have been previously made to issue photographic atlases of skin diseases, notably the *Photographic Review* of Duhring and Maury, *Revue Photographique* of Montméja, the series of Damon, of Boston, that of Squire, of London, as also the Italian work of Manassei and that of Profeta, recently reviewed in the ARCHIVES. In the present work the pictures are not reproduced by photography, but by a new process akin to the well-known heliotype and alberttype, so that while they are perfect representations of the cases presented, they have the advantage of not having the unpleasant gloss present in photographs, and also that they will not fade through age and exposure to light.

In the present atlas the portraits are each colored by hand to a very slight degree, and differ very considerably in their excellency in this respect; thus the coloring on the leprosy case is exceedingly dauby, and that on the representation of psoriasis is far too high, as is also that on the case of acne, rosacea; moreover, the dilated veins represented in this latter would be nearly the size of a small quill if the picture were magnified to life size.

While we have found photographs to be excellent helps in teaching when one has a large assortment of colored plates and models as well, we cannot but feel that they fail to convey to the eye the essentials of the eruption which are afforded by well-executed lithographic work, as that of Hebra's Atlas, that of the Sydenham Society, or that of Dr. Duhring. The subjects of illustration in these two parts are happily chosen for photographic effect,—the illustrations of comedo and ichthyosis are simply perfect,—but from our knowledge of other photographic collections, we fear the editor will have great difficulty in conveying the correct idea of the disease in certain other affections, as in tinea circinata, erythema nodosum, and other forms of erythema, many of the forms of eczema, also some of the syphiloderma, etc., if, indeed, it is not impossible to properly portray them by photography. At the best, a photograph can show but the elements existing in a single case, and all know how exceedingly rare it is to find a perfectly typical case, and how little cases resemble each other, whereas a picture should present such features as will enable its possessor to recognize all the phases of the disease by means of it.

The accompanying letter-press is well written, and represents advanced dermatological thought. The rules for treatment are excellent, though often rather too brief.

The mechanical execution of the work is thus far excellent. The plates are about 4 by 6 inches, on good card-board 10 by 12 inches. The typography is clear. The whole work, twelve parts at two dollars a part, will be cheap for the service it will render, but, (although comparisons are unpleasant), considering the low price of the magnificent lithographic Atlas of Duhring, at two dollars and a half a part, with also four plates each, we should have expected the present one at a much lower figure.

*Notes on the Treatment of Skin Diseases.* By Robert Liveing, A.M., M.D. Cantab. Fourth Edition. London, 1877, 12mo. Pp. 127.

Recently we had occasion to review the excellent little book by this author on the "Diagnosis of Diseases of the Skin," but the present fourth and last edition of this little note-book on treatment was overlooked. If these small handbooks on treatment could always fall into the hands of just the right persons they would be of great service, but, as remarked recently when reviewing an "Epitome of Skin Diseases" by the late Dr. T. Fox, they are often if not generally seized upon by ignorant physicians, hoping to get in a nutshell what they are too lazy to acquire by hard work, and the prescriptions are too frequently used without any proportionate knowledge of the diseases to be treated.

This book of notes was prepared originally for private circulation among the author's class in cutaneous medicine at the Middlesex Hospital. To those studying the branch they would be of inestimable value in recalling what had been taught. The book contains very little original matter, and the treatment is very largely that of Hebra, although considerable reference is made to other sources as well.

The descriptions are in the main very good for their length; the nomenclature is excellent, with few exceptions. We are surprised to find alopecia areata still described under the name tinea decalvans, although the author by no means supports the parasitic nature of the disease. In regard to tinea tonsurans he remarks, "The exact part played by the parasite in this and some other diseases of the skin still remains doubtful. It is sufficient to state here that though the fungus is not perhaps an essential part of the malady, yet it so far modifies this and several other forms of skin diseases as to justify our retaining the name 'parasitic,' which has been applied to them."

The diseases are supposed to be treated of in alphabetical order, which is not wholly the fact, but a good index renders everything very accessible. As a manual of ready reference to refresh the mind in the matter of actual treatment, the book must certainly prove very convenient to those not daily in contact with diseases of the skin.

*The Pharmacopœia of the British Hospital for Diseases of the Skin.*  
Edited by Balmanno Squire, M.B., Senior Surgeon to the Hospital.  
London, 1879, 12mo. Pp. 80.

Some years ago Mr. Startin, of the famous Blackfriars' Skin Hospital, issued a very small book containing the prescriptions in daily use there in treating diseases of the skin, and its large sale testified that such a record of practical work was desired by the profession. That is long out of print, and exceedingly difficult to obtain.

Mr. Squire now gives us a record of the prescriptions in use in another institution, with which he has been connected some time, and as he is known to be fertile in therapeutic resources, the book is a welcome addition to the literature of dermatology.

But the work is open to a number of minor criticisms which should receive attention. First, we notice the absence of many combinations of remedies, which made the formulæ suggested by Mr. Startin of such great value; thus, the unguentum hydrargyri cum plumbo, so constantly used at Blackfriars', does not seem to be employed at the British Skin Hospital, and in very many cases the prescriptions consist of very little more than stating the doses of the single remedies to be employed, without any further indications in regard to them. In the matter of chrysophanic acid, a single prescription is given for an ointment, of the strength of two drachms to the ounce, and no suggestion is added with regard to the use of the remedy in less strength, whereas, in the experience of very many, it is the exception when this strength is well borne. The only mention of the use of sulphurous acid is of it diluted,—two drachms to the ounce of water,—an almost uselessly weak application; the difficulty usually is in securing a strong enough solution of the gas, even when the officinal acid is used in its full strength.

The only formula for mixed treatment in syphilis is one giving as a dose one-eighth grain of the red iodide of mercury combined with one-half grain of iodide of potassium, in water, "used as a specific in cases of syphilitic eruptions;" the only other mention of iodide of potassium being a five-grain dose, "used in cases of plastic deposit complicating syphilitic or other eruptions." We certainly should want more effective measures in treating our cases of syphilis in and out of hospital. Of the glycerole of the sub-acetate of lead, to which Mr. Squire has directed so much attention, he merely records it thus: "Pigmentum Plumbi. The Plumbi sub-acetatis liquor, made with glycerine instead of water, used (diluted to a varying extent with glycerine) as an astringent and sedative in cases of chronic eczema." He gives no hint as to the amount of dilution. We would really like to know what Mr. Squire now thinks of this remedy, which he once lauded so highly; in our hands and in those of some of our friends it has by no means yielded the brilliant results which might be expected from the first accounts given of it by its originator.

The term "Pigmenta, pigments," used to indicate liquid applica-

tions to the skin, seems to be an English innovation for which we can see no ground; we cannot perceive the difference between those remedies given under this head and those described under "Lotiones, lotions." Thus, glycerine mixed with water, in equal parts, is found among lotions, while glycerine, mixed with alcohol, in equal parts, is placed among "Pigmenta," and to both are attached the direction, "used as an emollient in cases of ichthyosis." The same is true of two preparations of the subacetate of lead, which latter, when combined with water (page 29), is called a lotion, and with glycerine, a pigment (page 45). Space forbids criticism of many of the prescriptions which we had marked for this purpose, for we can hardly believe that all of them are actually used at the hospital or elsewhere, so contrary are they to what our experience would sanction. There is an amazingly full index, occupying twenty pages of the eighty, or one quarter of the whole, which renders all the materials of the book very accessible.

*The Hygiene of the Skin.* By J. L. Milton, Senior Surgeon to St. John's Hospital for Diseases of the Skin, etc. Eleventh thousand. London, 1879, 12mo. Pp. 98.

"The object of this work is to offer a set of rules for preserving the skin in a high state of health, and assisting the restoration of it to a proper standard when the reader is under treatment for disease affecting this part of the frame." The aim thus indicated is indeed a good one, for the public are grossly ignorant in regard to the simplest points bearing upon the subject; the desire for such information is shown in the fact of this being the eleventh thousand of this little brochure.

The work is very fairly accomplished, though we must say that there is room for considerable improvement. Most of the directions given would meet with the hearty approval of those acquainted with the subject; but the directions in regard to wines in skin diseases are certainly not applicable as far as relates to patients in this country. Much good information is given in regard to soaps, about which the greatest ignorance prevails. Mr. Milton gives the most unqualified endorsement and recommendation of Pears's transparent soap, especially that made for hospital use, without perfume, which, he says, when made into a lather can be applied even to a surface abraded by eczema. This certainly is a strong recommendation, and while we doubt the propriety of thus sanctioning the free washing of eczematous surfaces, we believe it to be the fact that the soap referred to probably represents the highest perfection which has been reached in this line. Unfortunately, however, human experience shows that when a great reputation has been established for any one article of commerce the standard of excellence almost invariably becomes lowered, and that which once represented the best sinks lower in the scale, both by the gradual improvement in other grades with which it is compared, and as a result of carelessness or cupidity on the part of the proprietors of the article in question. We can only hope that this will not be the result in the present instance.

Mr. Milton enters a very good crusade against the sulphur soaps, tar soaps, carbolic soaps, etc., which are advertised to cure every skin disease, and very properly shows the public that it is impossible for them to effect the cures claimed, whereas the injury occasionally produced by them is very great. Also, in regard to such "soothing soaps" as elder-flower, lettuce, mallow, etc., he makes the very true remark, "I believe it is the custom to manufacture whole tons in which there is not a single drop of the article from which it derives its name, and in virtue of which it is supposed to possess some marvellous soothing property."

Wholesome directions are given in regard to bathing and exercise, and he cautions against the ill effect so often observed upon very many skin diseases from sea-bathing.

If the public knew and acted upon all the instructions in this little book there would be fewer cases of skin diseases to treat, and these would be more easily managed. There can no longer be any doubt of the propriety of medical men properly enlightening the public on medical matters.

*A Concise Epitome of Cutaneous Diseases according to the Latest and Most Approved Classification; Compiled from the Best and Most Recent Authorities.* By J. E. Sanborn, M.D. Rockport, Mass.

The idea of this is excellent ; it is a chart 28 by 22 inches, on which the subject is arranged in eight columns, giving classification, name, symptoms, varieties, causes, diagnosis, prognosis, and treatment of the more common diseases of the skin. There are twenty-six diseases mentioned, arranged in eight classes, and these classes are those of Willan, with the addition of the group of parasitic affections.

Many of the descriptions are good, though necessarily brief ; the diagnosis, treatment, etc., are also well stated in the main, but there are, unfortunately, errors which either do not warrant the statement that it is compiled from the best and most recent authorities, or show that the compilation was not perfectly and judiciously performed. Witness such examples as the following : " favus has pustules" ; " grocer's itch" is regarded as a form of psoriasis ; lepra (now applied to leprosy) is spoken of as a declining stage of psoriasis ; syphilis is reckoned as a cause of lupus and psoriasis ; alopecia areata is placed as a parasitic disease, with the name tinea decalvans ; the roots of hairs taken from parasitic sycosis are said to be covered with a whitish powder,—the fungus of the microsporon mentagrophytes, etc. Syphilis is omitted entirely from special consideration, as also are necessarily very many other diseases.

The chart was evidently made for the author's own use, to simplify the subject, and so it certainly does, and the desire is very laudable to extend the same aid to others ; but such a chart should be accurate, and cannot properly be "*compiled*," it should be *written* by one thoroughly conversant with the whole subject from much practical experience.

*Bibliotheca Dermatologica. Catalogue of cutaneous literature in the library of Henry G. Piffard, M.D., Professor of Dermatology, University of the City of New York.*

This is an elegantly gotten-up pamphlet of thirty-seven pages, in large type, issued by the author. It contains a list of books, monographs, etc., on diseases of the skin, which, although by no means complete, is perhaps the largest thus far published. It will be convenient for collectors in this line.

*Notes on Tinea Imbricata, an Undescribed Species of Body Ring-worm.* By Patrick Manson, M.D. China: Imperial Maritime Customs. II. Special Series, 2. Medical Reports. 1879.

Dr. Manson, who resides at Amoy, China, differs from Dr. Tilbury Fox and those who believe in the identity of many of the diseases of different countries presenting vegetable fungi, as Burmese ringworm, eczema marginatum, Malabar itch, Chinese itch, etc., and seeks to demonstrate that there is at least one peculiar eruption in China, with a vegetable parasite capable of inoculation, which is quite distinct from tinea circinata.

This disease he calls tinea imbricata, from the peculiar way in which the scales are attached on the edge, and from the disposition in the eruption to take the form of concentric circles. Tinea circinata is also common in China, and Dr. Manson describes a case to show the difference between the two affections. He further inoculated the tinea circinata on the arm of an assistant, and after producing a perfect eruption, in which the fungus was found, he inoculated the same person on the other arm with the scales from a case of tinea imbricata, and succeeded in producing a lesion corresponding to this disease, thus giving the same person the two parasitic eruptions at the same time, with quite different appearances.

The microscopic appearances of the parasites are described as different: in the tinea imbricata the fungus is much more abundant, and conidia are found readily in single rows or long, often-branching chains, while the mycelium is much less freely developed.

The report is illustrated by a number of photographs and two large pages of lithographic drawings. Artistically, all these are far from being what might be desired, and the photographs, indeed, convey but little idea of the true disease, but in want of better they assist somewhat in opening the subject. Dr. Manson was one of the contributors to the work edited by Drs. Fox and Farquhar on endemic skin and other diseases of India, etc., and described this form tolerably clearly at that time, expressing then the view that it was a variety of disease distinct from ordinary ringworm.

Such studies by competent gentlemen residing in localities where peculiar diseases manifest themselves cannot be too highly praised, and certainly do much to advance science. The liberality of the English government in affording such means of publication, and especially of illustration of disease, is commendable indeed, and indicates the wisdom of the administrative officers.

## BOOKS AND PAMPHLETS RECEIVED.

*Transactions of the American Gynæcological Society.* Vol. iii., for the year 1878. Boston, 1879. Octavo. Pp. 472.

*Sixth Annual Report of the Secretary of the State Board of Health of the State of Michigan for the Fiscal Year ending September 30, 1878.* Lansing, Michigan, 1878. Pp. 355.

*Seventh Annual Report of the Secretary of State of the State of Michigan, relating to the registry and return of Births, Marriages, and Deaths for the Year 1878.* Lansing, 1879. Pp. 346.

*Lectures upon Physiology: a preliminary course of lectures on the influence of physiology on practice, on the conservation of force, on the origin of life, etc.* By James T. Whittaker, M.A., M.D., Professor of Physiology and Clinical Medicine in the Medical College of Ohio, etc. Cincinnati: Chancy R. Murray, 1879. Small octavo. Pp. 288.

*Health, and How to Promote it.* By Richard McSherry, M.D., Professor of Practice of Medicine, University of Maryland, President of the Baltimore Academy of Medicine, etc. New York: D. Appleton & Co., 1879. Small octavo. Pp. 185.

*Lectures on Electricity in its Relations to Medicine and Surgery.* By A. D. Rockwell, A.M., M.D., Electro-Therapeutist to the New York State Woman's Hospital, etc. New York: Wm. Wood & Co., 1879. Octavo. Pp. 99.

*Pott's Disease, its Pathology and Mechanical Treatment, with Remarks on Rotary Lateral Curvature.* By Newton M. Shaffer, M.D., Surgeon in charge of the New York Orthopædic Dispensary. New York: G. P. Putnam's Sons, 1879. Small octavo. Pp. 82.

Health Primers. New York: D. Appleton & Co., 1879.

1. *Exercise and Training.* By C. H. Ralfe, M.D. Pp. 96.
2. *Alcohol, its Use and Abuse.* By W. S. Greenfield, M.D. Pp. 95.

3. *The House and its Surroundings.* Pp. 96.

4. *Premature Death, its Promotion or Prevention.* Pp. 94.

American Health Primers. Philadelphia: Lindsay & Blakiston, 1879.

1. *Hearing, and How to Keep it.* By Charles H. Burnett, M.D., Consulting Aurist to the Pennsylvania Institution for the Deaf and Dumb, etc. Pp. 152.

*2. Long Life, and How to Reach it.* By Joseph G. Richardson, M.D., Professor of Hygiene in the University of Pennsylvania, etc. Pp. 160.

*Contribuzione alla clinica generale e speciale dell' entero-peritonite sifilitica.* Del Dottor Primo Ferrari. Catania, 1879. Pp. 13.

*Paraplegia in Syphilitic Subjects.* By E. C. Seguin, Clinical Professor of Diseases of the Mind and Nervous System at the College of Physicians and Surgeons, New York. Pp. 13. Reprinted from ARCHIVES OF DERMATOLOGY, April, 1879.

*Psoriasis ed acido crisofanico.* Del Prof. Pietro Gamberini.

*Fibroma Mollusco Virchow.* Clinica del Prof. Pietro Gamberini.

*Un caso d'idros adenite sifilitica.* Narrato del Prof. Pietro Gamberini.

*Zur Histologie der Psoriasis Vulgaris.* Von Prof. Isidor Neumann. Pp. 14, with lithographic plates.

*A Case of Scleroderma vel Morphæa, with Hemiatrophy Facialis, Alopecia Areata, and Canities.* By V. P. Gibney. Reprinted from ARCHIVES OF DERMATOLOGY, April, 1879.

*A Case of Morphæa.* By P. Albert Morrow, M.D., New York. Reprinted from ARCHIVES OF DERMATOLOGY, April, 1879.

*Further Contributions to the Treatment of Lupus.* By Henry G. Piffard, Professor of Dermatology, University Medical College, New York. Reprinted from the *Medical Record*, April 5, 1879.

*Ueber der sogenannte Kerion Celsi.* By Prof. Auspitz. Separat-abdruck aus der *Wiener Med. Presse*.

*Urethrismus, or Chronic Spasmodic Stricture.* By F. N. Otis, Clinical Professor of Genito-Urinary Diseases in the College of Physicians and Surgeons, New York. Reprinted from the *Hospital Gazette*, April 19, 1879.

*Second paper on above subject, in reply to Dr. H. B. Sands.* By same author.

*On Spasmodic Stricture of the Urethra : a Reply to Dr. F. N. Otis.* By Henry B. Sands, M.D., Professor of the Practice of Surgery in the College of Physicians and Surgeons, New York, etc. Pp. 12.

*Retroversion in Relation to Laceration of the Cervix Uteri, etc.* By Nathan Bozeman, M.D. New York. Reprinted from vol. iii. *Gynecological Transactions*, 1879. Pp. 18.

*The Structure of the Vessels of the Nervous Centres in Health, and their Changes in Disease.* By Theodore Deecke, Special Pathologist New York State Lunatic Asylum, Utica. Parts I., II., and III. Pp. 35. Reprinted from the *American Journal of Insanity*, July, 1877, January and April, 1879.

*Fracture of the Pelvis during Instrumental Delivery, with an Illustrative Case.* By W. H. Studley. New York. Reprinted from the *American Journal of Obstetrics and Diseases of Women and Children*, Vol. xii., April, 1879. Pp. 13.

*Eye Troubles in General Practice.* By Henry D. Noyes, M.D. New York. Pp. 24. Reprinted from the *New York Medical Record*, April 19, 1879.

*The Radical Cure of Hernia by the Antiseptic Use of the Carbolized Catgut Ligature.* By Henry O. Marcy, A.M., M.D. Cambridge, Mass. Pp. 23. Reprinted from the *Transactions of the American Medical Association*, 1878.

*On the Traumatic Origin of Subfacial, Deep-Seated, or Cold Abscess, commonly called Constitutional or Scrofulous Abscess.* By Lewis A. Sayre, M.D., Professor of Orthopædic Surgery, Bellevue Hospital Medical College. Pp. 16. Reprinted from the *New York Medical Record*, March 29, 1879.

*Sixteenth Annual Report of the New York Society for the Relief of the Ruptured and Crippled.* May, 1879.

*Eleventh Annual Report of the New York Orthopædic Dispensary and Hospital.* 1879.

*Eighteenth Annual Announcement of the Bellevue Hospital Medical College.* Session 1878-1879.

*Annual Announcement of the Medical Department of the University of Buffalo.* Session of 1879-1880.

*Progress and Prospects of the Buffalo Medical College.* Speech by Professor James P. White, M.D.

## MISCELLANY.

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**Death of Dr. Tilbury Fox.**—In the death of Dr. William Tilbury Fox dermatology has lost an earnest and faithful worker, medicine has lost a bright investigator, many patients have lost a very serviceable advisor, and we have lost a warm personal friend. There was a geniality about Dr. Fox which drew every one to him, while his enthusiasm in his branch of study and practice captivated students and made all feel at home when with him.

Dr. Fox died very suddenly, at the age of forty-three years, in Paris, June 7, 1879. His health had suffered greatly in late years, largely from overwork, and he had not gained after his vacation each year. Last summer he appeared really prostrated, and, although full of animation at times, it was easy to see that he was far from well. For some years he had known of the existence of serious aortic disease, and had exercised considerable care in guarding his health. At the time of his death he was in Paris, where he had gone for a short rest. He had had several attacks of angina, and on the eve of returning to London, in his ordinary health, he was again seized with angina at two o'clock in the morning, and died soon after.

No living English physician, except Mr. Wilson, was so well and widely known in connection with diseases of the skin as was Dr. Fox. Most of his writings were of an intensely practical character, written largely for the general physician; and while he has done very much to advance the scientific progress of dermatology, and has accomplished work which will be appreciated by specialists, his *forte* undoubtedly was instructing the profession in the plainer and more homely portions of the branch. He wrote very few abstract articles or reports of very new or unusual cases, but rather therapeutical articles suited for the practitioner of general medicine; this it is which gave him his strong hold on the profession, and his practice largely remunerative in later years. Dr. Fox cultivated American acquaintance and practice, and received a good share of the cases sent from this country abroad. Patients were invariably pleased with him, and he was undoubtedly a very successful practitioner in affording relief in disease.

The literary career of Dr. Fox is well known to most of our readers, but it may not be amiss to here record it. Born the son of a physician, in 1836, he entered the medical school of University College in 1853, and obtained the degree of Doctor of Medicine in London in 1858. As a student he displayed especial zeal, and was

the recipient of honors. He became house-surgeon to Quain, at the University College Hospital, and house-physician to Jenner, from the latter of whom he acquired his early taste for and knowledge of skin diseases. His first inclination was to midwifery, and he received the appointment of physician-accoucheur to the Farringdon General Dispensary, and contributed to the literature of the subject.

Becoming, however, interested in parasitic diseases, he wrote a book of 210 pages on "Skin Diseases of Parasitic Origin: Their Nature and Treatment. Including the Descriptions and Relations of the Fungi found on Man;" published in London, 1863. This, at the time, was certainly a very complete and intelligent statement of the case, and shows a great deal of study and thought; and there is much in it which will long be of interest and value, although progress has been made since in certain points. Dr. Fox next put out a general work on Skin Diseases, in 1864, of which a second edition appeared in 1869, as a small duodecimo of 472 pages. This was reprinted in New York, and a third, large octavo edition, of 532 pages, was issued in 1873, which was also republished here. These have been reviewed previously, and need not be specially noticed, except to recall the peculiarly easy and conversational style in which Dr. Fox always wrote, and a certain carelessness which was not always so pleasant.

In 1869-70 he delivered the Lettsomian Lectures before the Medical Society of London, and chose for his subject "Eczema." They were published in a volume in 1870, and are indeed a valuable, plain, and practical study of the disease. In 1875, finding that there was a call for a smaller work than that which he had previously written, he published an Epitome of Skin Diseases, which was republished in this country, as also a second edition, which appeared in Philadelphia in 1869, and which was reviewed in the last issue of the ARCHIVES; in preparing the latter he was assisted by his brother, Dr. T. C. Fox. In October, 1872, Dr. Fox, with Dr. Farquhar, drew up a "Scheme for obtaining a better knowledge of the Endemic Skin Diseases of India," which was widely circulated by the government to the medical officers in India, and afterwards to other portions of the world. The result of this was the collection of a large mass of valuable information in regard to many obscure diseases, which was published in 1876, in an octavo volume of about 430 pages, with illustrations, which forms a very important addition to dermatology, and which will long be of the greatest service to the student of dermatology, as well as to physicians living in hot climates.

The last large literary work undertaken by Dr. Fox was the publication of an atlas of diseases of the skin, based on that of Willan and Bateman, which was begun on October 1, 1875, and finished in about two years; this was also republished in this country. Much labor was involved in this, as many of the plates were new, and all of the letter-press, which was extensive.

These works represent but a portion of the literary work done by Dr. Fox during his active but comparatively brief career ; he was a most indefatigable contributor to the medical periodicals, and for many years was connected editorially with the London *Lancet*. He was also often at the societies, presenting cases and specimens, and taking part in discussions. The much discussed subject of dysidrosis interested him to the last, and one year ago he demonstrated to the writer with great earnestness his recent microscopical studies on the subject ; in this latter work he was much assisted by his brother.

Dr. Fox labored incessantly also in public practice. He was at first physician to the Skin Department of Charing Cross Hospital and lectured there ; subsequently, on the death of Dr. Hillier, he was appointed physician to the Skin Department of the University College Hospital, where he delivered a number of courses of lectures. Here he had in addition to the out-patient department a number of beds in the wards, and was instrumental in having a large suite of baths introduced into the hospital, for the treatment of diseases of the skin.

Dr. Fox represented the highest type of a genial, earnest, honorable, and conscientious Englishman, filling his position in life nobly ; he was cut down in the midst of usefulness and while reaping the reward of his diligent performance of duty. During later years his practice has been very large and remunerative, but we regret to learn that this had been for too short a time to allow him to make the ample provision for his family which should be the result of such a life.

He was much interested in the success of his brother, Dr. T. C. Fox, who had worked much with him in later years and had taken his practice when absent, and who gives promise of much success in this line. He is now finishing and publishing some of the uncompleted work of Dr. Fox, according to his special request.

In regard to the influence exerted upon dermatology by Dr. Fox, it is perhaps a little soon to express any opinion on the subject. Certain it is that he awakened much interest in this branch by his own enthusiasm and hard work : certain it also is that his plain, practical writings have done a great deal to enlighten the profession here and in England in dermatology. He did not advocate any new or peculiar views with special vehemence, unless those in regard to the nature of dysidrosis be so considered, consequently he cannot be said to have many who follow or oppose his teachings ; he was eminently conservative.

He did, however, introduce an element of eclecticism into English dermatology ; it might be said that he broke it away from the influence of Wilson, making use of the elements of progress found in other nations ; he introduced the study of pathological anatomy into his book from the Germans, and also much of the humoral views of the French ; and although his constant reference to Willan, and the fact of his partial reproduction of Willan's *Atlas* might, at first thought, indicate a step backward, still this will be seen to be

but a recognition of what was good in the past as well as the present, and marks him only as the man of enlarged views. We cannot but mourn the loss which dermatology has suffered, and hope that each one now pursuing this branch may be as earnest, diligent, and true as was Dr. William Tilbury Fox.

**Death of Dr. Maury.**—Although not widely known in connection with dermatology, Dr. Francis Fontaine Maury held for a number of years the position of Lecturer on Dermatology and Syphilis at the Jefferson Medical College of Philadelphia. He was pre-eminently a surgeon, and one of the most skilful ones in Philadelphia, being surgeon to the Jefferson Medical College Hospital and to the Philadelphia Hospital. For two years (1870-1872) he edited with Dr. Duhring the *Photographic Review of Medicine and Surgery*, and his clinical lectures on Diseases of the Skin and Syphilis have been reported from time to time in the journals.

He died of pulmonary disease, in Philadelphia, June 4, 1879, in the thirty-ninth year of his age.

**Death of Dr. Léon Guérard.**—Dr. Guérard was interne in the Hôpital St. Louis, Paris, for a long time with the late M. Bazin.

In 1865 he collected and published the second volume of the "Leçons Théoriques et Cliniques sur les Affections Génériques de la Peau," by Bazin. The state of his health had forced him to a very quiet life, and we do not recall other dermatological contributions from him, except occasional communications to the *Annales de Dermatologie et de Syphiligraphie*, principally in the way of reports from the Hôpital St. Louis.

**Dermatology in Baltimore.**—We are glad to record that Dr. I. Edmondson Atkinson, one of the founders of the American Dermatological Association, a contributor to the ARCHIVES, and now one of our collaborators, has been appointed Clinical Professor of Dermatology in the School of Medicine of the University of Maryland. The profession is beginning to be awakened to the disgraceful neglect in which this branch has lain in the past, and slowly the schools are according dermatology its proper place.

**New York Hospital for the Relief of the Ruptured and Crippled.**—This, we believe, is the first hospital in this city to recognize the necessity of the services of a specialist in diseases of the skin; its managers have recently created the office of dermatologist to the institution, and tendered it, unsolicited, to Dr. Bulkley. In the large out-patient clinic, as well as in the wards, there are constantly cases of the greatest interest, dermatologically, and the medical officers in recognizing the propriety of seeking special aid have again showed their enlarged views, and have laid the profession under an obligation. All our hospitals, from time to time, contain cases of diseases of the skin, including syphilis, which are of the

very greatest importance, but which, from a necessary lack of interest or knowledge on the part of the attending staff, are not utilized.

We look forward to the time when every hospital will have its staff of consultants in the special departments, who shall have beds which may be used in furthering their branches. It is only a wonder that the public, who outside of the hospital are free to seek the aid of a specialist, do not demand that the same right shall be accorded to the unfortunates whom Providence has consigned to the hospitals.

**One hundredth meeting of the New York Dermatological Society.**—On page 268 are given the minutes of the hundredth regular meeting of this Society. Organized in 1869, this association has at the date of writing been more than ten years in active operation, and the one hundred meetings by no means represent all the work done: there have been many special meetings, besides many meetings of committees. This record, we believe, is unequalled, and we only call attention to it to stimulate the interest of others in this branch, and to attest from personal experience the very great pleasure and profit which has resulted from this frequent exchange of views by those specially interested in this branch, as also the very greatly enlarged experience which results from the opportunity of seeing the rare and interesting cases occurring in the practice of others.

**American Dermatological Association.**—The third regular annual meeting will be held in the city of New York, on August 26, 27, and 28, 1879. The programme has not yet reached us, but, judging from former meetings, an interesting one may rightly be expected. We very much wish that some of our foreign *confrères* could and would join us.

**British Medical Association.**—At the coming meeting, to be held in Cork, Ireland, August 5, 6, 7, and 8, 1879, there will be a sub-section devoted to dermatology, at which the late Dr. Tilbury Fox was expected to preside. Voluntary papers are expected, but there is also to be a special discussion on "Lupus, its Varieties and Treatment." It is earnestly hoped that a careful discussion of the subject by competent men will aid in a settling of the views of the profession as to what forms of morbid action should be thus called, about which the minds of some seem still to be confused. The treatment also needs light to be thrown upon it. In the absence of other convocations of those interested in dermatology, we rejoice that our British friends will have this opportunity of coming together.

**American Medical Association.**—At the last regular meeting of this Association the proposition to form a separate section of dermatology and venereal diseases was rejected. We consider this

opportune: with a society in New York City, and another special one for the country at large, a branch of the American Medical Association would fail to draw to it many of those especially interested in dermatology; and a discussion of these subjects by those acquainted with them only in a general manner could not but result in something worse than a failure. Five, ten, or twenty years hence, when the rising generation shall have been thoroughly instructed in this branch, and when definite ideas on dermatology shall have prevailed throughout the mass of medical men, a public discussion would be of more service to those participating, and to the profession at large.

**Leprosy in America.**—There are thirteen cases of this disease in Louisiana, according to Dr. L. F. Salomon. They are, with one exception, of the tubercular variety. No mode of treatment seems to have been at all efficacious with them.—*New York Medical Record*, July 19, 1879.

# ARCHIVES OF DERMATOLOGY.

OCTOBER, 1879.

## ORIGINAL COMMUNICATIONS.

### CASE OF INCOMPLETE VITILIGO.\*

BY J. EDMONDSON ATKINSON, M.D.,

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REFERENCE has been made by several writers upon dermatology to a paper by the late Dr. Hermann Beigel, in *Virchow's Archives* for 1868 (p. 529), upon "Albinismus and Nigrismus." In addition to general and partial albinismus, the author there refers to a third form of deficiency of cutaneous pigment which he terms semi-albinismus, and which he declares can only be recognized in negroes; it being impossible to distinguish the differences of shade, even if they occur, in the more faintly pigmented white races. The term semi-albinismus would signify about the same, with regard to degree of cutaneous pigmentation, as partial albinismus indicates with regard to extent, in both whites and blacks. It is proper to add, however, that Beigel's acquaintance with the condition is derived entirely from Captain Burton, the African traveller, from whose book, "Wanderings in the West of Africa, from Liverpool to Fernando Po, by an F.R.G.S.," the case in question is quoted. "I saw another anthropological curiosity at Accra," says this author (page 63, vol. ii.). "The albino in Africa has been noticed by every traveller; the semi-albino has not. My specimen was a man with features and cranium distinctly belonging to the 'poor black brother.' His complexion, however, was *café au lait*, his hair a dull yellow, short and kinky, as that of all his tribe, and his eye-pupils were of a light and lively brown. I afterwards saw many of the same temperament at Benin, and one, the chief Shandy, at Batanga."

Although the term albinismus is made to include both congenital

\* Read before the American Dermatological Association, New York, August 26, 1879. For discussion thereon, see page 370.

and acquired conditions by Beigel, it is evident that we have here to do with a congenital deficiency of pigment, a semi-albinismus, as Captain Burton aptly designated it. This abnormality would be, naturally, not encountered, or at least very difficult of recognition, in the white races, and is of interest as supplying a link to the chain of pigmentary pathology. It has been my fortune, recently, to have encountered a patient whose skin presented peculiarities bearing the same relation to acquired leucoderma or vitiligo as the case described by Burton bears to congenital leucoderma or albinismus. And as I am not aware that a similar observation has been recorded, I have thought that the following case might be of interest.

*Baltimore Special Dispensary, June 20, 1878.*—Sarah Washington, a dark mulatto, 25 years old, first applied here for treatment May 1, 1877. She is a prostitute, of clear, smooth skin, clean and tidy in dress and person, of healthy appearance and immense size. Her height is 171 centimetres (5 feet 8 inches.) She measures around the chest just above the nipples, 166 centimetres (5 feet 6 inches); around the body at the level of the umbilicus, 114 centimetres (3 feet 10 inches); around the buttocks, 132 centimetres (4 feet 5 inches); around the thigh at the level of the perineum, 74 centimetres (2 feet 6 inches); and around the arm just below the axilla, 36 centimetres (1 foot 2 $\frac{1}{2}$  inches). Her family history is most incompletely obtainable, and is essentially negative. She menstruated first when fourteen years old, and ceased to be a virgin at seventeen years. She has always menstruated regularly, but with discomfort. She has never been pregnant. Her nipples are small, as in nulliparæ. The cervix uteri bears no evidence of former pregnancy, nor can any such be discovered in the abdominal integument. According to the patient's account she has never had syphilis, and she does not show, after careful examination from head to foot, the smallest sign of this disease. The only venereal complaint she has ever had was an acute vaginitis, for which she was treated by me during the past year. She is of temperate habits, so far as concerns the use of alcohol. She says that she has been so large no longer than five years, previous to which time she was rather slender.

The present affection began about four years ago, upon the back of her right hand. In the course of a year or two it had invaded the back of the other hand, the forearms, the arms, neck, lower extremities, buttocks, and the anterior portion of the trunk. When she was examined by me, May 1, 1877, the condition was essentially as now, except, it is to be noted, that inasmuch as she declared the disorder to have begun upon the backs of the hands, these parts were closely scrutinized, and it was entered in her register that the skin of both hands was absolutely free from abnormal appearances.

At the present writing, June 20, 1878, the backs of both hands, the forearms and arms, more especially upon the flexor surfaces, but also freely upon the extensor aspects, the neck, the breast, the abdomen, the buttocks, the thighs, and the legs, in fact, nearly the whole surface, except the face, the scalp, and the back, which en-

tirely escape, are irregularly invaded by the following changes, most noticeable upon the forearms. These various portions of the skin are seen to be colored in different shades: a dark one, which forms the ground color and is the normal hue; a still darker ring, the well-known border of the vitiliginous patch; and finally, a central much lighter hue, which involves an immense number of irregularly distributed discrete and confluent spots. These spots vary so much in size and are so very different in outline, and their intercommunications are so extensive, that it is almost impossible to ascertain their exact size; as measured, however, they range from 1 centimetre to 4.5 centimetres in diameter, the greater number being circular and about 1 centimetre in diameter. When larger than this they lose their discoid appearance and become very irregular, and sometimes in running together they enclose little islets of more darkly-colored integument. They are most extensive upon the forearms, where they occupy probably more surface than the healthy portion, the ulnar extensor surface alone escaping.

The contrast of color is most marked upon the neck, where the normal color is darker. Here the color is not only diminished in irregularly circular patches, but the decolorization follows the natural folds of the skin. The lines of lighter color thus formed attain a length of 25 millimetres, by a breadth of from 2.5 millimetres to 1 millimetre; but as they frequently coalesce with other similar lines, measurement becomes difficult. Upon the breast the spots are relatively few, but there are here a number of vertically running atrophic striæ of an abnormally light color, such as are commonly seen upon fat persons and upon the abdomen after pregnancy. The abdomen is free from the spots as low down as the level of the umbilicus; below this they again become very numerous, but do not exceed 1 centimetre in diameter. There are here none of the atrophic striæ as seen upon the neck. The skin around the waist is much darker than elsewhere, and this is evidently due to the pressure of the bands of her garments. The buttocks are very freely spotted with the decolorized areas. The thighs anteriorly are free from the spots, but are abundantly marked with lines of atrophy of the skin like those seen upon the breast; posteriorly, however, the thighs are occupied by multitudes of spots like those described upon other parts. They extend down the posterior surface of the thighs and over the popliteal spaces for some distance down the calves.

The skin surrounding these spots is everywhere quite decidedly darker than that of the general integument, as is usual in vitiligo. It is most difficult to describe the difference in the coloration of the altered and normal regions. The lighter areas can by no means be justly termed leucodermic, since the hue is such as one daily encounters in some mulattoes and persons of more diluted African blood. There is not the slightest desquamation of the affected surfaces, and to the touch no difference can be detected. The whole surface is perfectly smooth and velvety, without infiltration and without atrophy, excepting the striations upon the breast and thighs.

The sensibility of the skin, as tested by the æsthesiometer, is everywhere perfect. The spots are not all decolorized to an equal degree, but vary within narrow limits, those upon the hands being slightly darker, possibly because they are there most recent.

The hairs, of which she has a very insignificant development, are not less numerous upon the affected parts than upon corresponding healthy surfaces, and show no loss of color whatever. Beyond a certain degree of anxiety and apprehension which causes her to watch the course of the disease narrowly, there are no subjective symptoms.

*December 12.*—There seems to be no change in the general character of the lesions. She still asserts that the patches "come and go;" and as an evidence of this she shows her hands, which are, indeed, at present, of a perfectly uniform and natural color, and show not the smallest trace of the lesions observed by me last summer. There is a very accurate symmetry observed in the general arrangement of the lesions in all parts of the body.

It is hardly worth while to attempt to describe the therapeutic attempts made by me upon this case, since there was not noticed the smallest result attributable to them. On the contrary, there really seems to be some increase in the extent of surface involved, although the degree of decolorization has not gone beyond that originally noticed, and by no means presents the striking deformity observed in the ordinary congenital and acquired leucodermata of the dark races.

Apart from the interest attaching to this case as exemplifying the well-established fact that in pathology, apart from specific influences, there are no clearly-defined barriers, rigidly separating one process from another related one, there are also here presented other considerations of importance. Most authors agree that in ordinary vitiligo a restitution of the normal pigmentation does not take place. In the case under consideration I was able to observe in portions of the surface, where error could be readily avoided (the backs of the hands), first, the complete absence of deficient coloration, subsequently, the existence of the vitiligo upon both hands, and finally, its complete recession from these parts. There are indeed other instances of this restoration of pigment upon record. One of the negroes seen by Captain Burton in Africa, and referred to by Beigel in the article already quoted, was, at the time of the observation, recovering his skin pigment. Dr. Thomas F. Wood, of Wilmington, N. C. (*Medical Examiner*, July 19, 1877), reports the case of a colored man aged 40 years, who, after having vitiligo for nine years, began to regain his cutaneous pigment in the order of its disappearance. In this case the decolorization does not appear to have been complete, the face and hands being not white, but as "bright as those of the brightest mulatto." Future investigations may show this incomplete form of vitiligo to be not uncommon.

Another point worthy of attention is the occurrence of the decolorization in the natural folds of the skin of the neck. This phenomenon has not escaped the observation of others studying pigmen-

tary atrophies. It has occurred to me, not unfrequently, to notice in negroes possessing long prepuces, which covered the glans, a complete leucoderma, beginning just at the preputial fold, extending back over its concealed surface and involving the glans, partially or entirely; indeed, just those portions placed in apposition with each other. In these cases the local condition of the parts manifestly acted as the determining cause in evoking the pigmentary atrophy, whether by the exclusion of light, the accumulations of moist discharges, or by friction is impossible at present to decide.

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A CONTRIBUTION TO THE STUDY OF THE BULLOUS  
ERUPTION INDUCED BY THE INGESTION OF THE  
IODIDE OF POTASSIUM.\*

BY JAMES NEVINS HYDE, A.M., M.D.,

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ON the 23d of June, 1879, I was visited by a female patient with an infant at her breast, who delivered a note from a physician of Chicago, in which the latter requested me to give an opinion as to the skin disorder with which the child was affected. From the statements made by this mother, and from the information subsequently given by her attending physician, the following history was obtained:

The father was and had always been an entirely healthy man. The mother had occasionally suffered from head- and back-ache, and from an affection of the skin which had at times troubled her since childhood, but which had not manifested itself since her marriage. At one time, however, since that date, she had suffered from a small abscess on the inner face of the thigh, which, after discharging, had healed without untoward symptoms. Upon examination, this woman was found to be free from all evidences of syphilitic infection. She was well developed, had an abundant supply of milk for her infant, and only exhibited a moderate pallor of the exposed mucous surfaces. The cicatrix left by the abscess described above had no suspicious features.

Soon after her marriage she had been delivered of an infant which speedily displayed an eruption upon the surface of its skin. This was, according to the diagnosis of her physician, a simple eczema of the face and scalp, which, though somewhat rebellious, yielded to appropriate treatment. When convalescing from this attack the child was seized with cholera infantum, and died in its ninth month.

The second pregnancy terminated in the birth of the present fe-

\* Read at the third annual meeting of the American Dermatological Association, New York, August 26, 1879. For discussion theron, see page 371.

male infant, Amanda Gabrielle, now eight months old. As in the case of the child which was lost, she had, soon after birth, exhibited over the skin of the face and scalp an eruption which was recognized by the physician to be a typical eczema capitis. This cutaneous disease had also proved persistent under the treatment employed, but had gradually improved until about one month prior to the present examination, when an abundant crop of boils had appeared over the scalp. These increased in number until the physician estimated that he had opened hundreds with the lancet in the region described. They gave exit to an abundant, creamy, and laudable pus, when the process of repair speedily followed. During that time the eczematous condition had gradually ameliorated. In spite of these accidents the case was progressing fairly well, when the complication ensued with regard to which my opinion was asked. This complication was the development of certain cutaneous lesions, of formidable aspect, greatly different from those previously observed.

Upon examination the little patient was seen to be a fat and well-nourished baby, with the eruption of six teeth accomplished. It was exceedingly fretful and irritable, no doubt partly in consequence of the extent of the cutaneous disease with which it was affected, and which was pretty surely the source of disagreeable, if not painful, sensations.

The entire scalp was covered with an extensive yellowish crust of moderate thickness, evidently composed of the dried exudation of a preceding inflammation of pustular type, together with the sebaceous secretion usually seen in such cases. Sparse and light-colored hair-filaments were embedded in the crust. Similar, less bulky, and slightly-reddened crusts covered also the temples and the upper portions of the cheeks. Here it was evident that the surfaces had been irritated by scratching, as the marks of the fingers and nails were to be distinguished. No pus was confined beneath the crusts either of the scalp or face. The acuteness of the inflammatory process had evidently subsided. Here and there could be seen the sites of the abscesses whose history has been given. In short, the external appearances of the portions of the body described were those of an ordinary eczema capitis in the phase of retrogression.

But over the extremities and nates an eruption of a distinctly different type was visible. It consisted of variously-sized vesicles and bullæ, displayed upon the arms, forearms, hands, palms, interdigital spaces, backs of the hands, wrists, nates, thighs, legs, ankles, dorsum of the feet, and the spaces between the toes. The smaller lesions were dispersed between the others, but the larger were grouped about the wrists and ankles. They were displayed upon both sides of the body, and were limited to similar localities on each side, so that a certain degree of symmetry was thus demonstrable. Proceeding upward and downward from a circlet surrounding the wrists and ankles, where, as has been stated, was the region of most plentiful development for the upper and lower extremities, the bullæ became progressively fewer and smaller. Thus there were but a few

small, imperfectly-developed vesicles upon the extremities of the fingers and toes, and above the elbows and knees. Those upon the nates were not only ill developed, but surrounded by hyperæmic patches and sparse, delicate crusts, suggesting that in this locality the two disorders of the skin had coexisted and their phenomena become intermingled.

The vesicular and bullous lesions varied in size from that of a large pin-head to a pigeon's egg, those fully developed far outnumbering all others. Though they were for the most part discrete, it was clear that some of the largest had resulted from coalescence, the partition-septa showing after rupture. Some were elevated above the general surface of the integument to the extent of from 8 to 10 millimetres. The smaller were roundish in shape; the larger were either globoid or—and this was not rarely to be noted—elliptical in contour. Often they showed as merely irregular and bulging projections from the general surface.

These lesions had no disposition to rupture, but were remarkably firm and persistent. According to the statement made by the physician, they had originally contained a serous and in some cases a semi-purulent fluid, but at the time of the observation now detailed there were very few which could be made to exude a fluid sufficiently thin to drop from between the fingers after rupture of the wall of the bleb. Each contained a semi-gelatinous mass, suggesting the appearance of boiled sago. The smaller bodies contained a thickened serum of high specific gravity. Here and there among these smaller bodies were slightly larger lesions resembling pustules and containing inspissated pus.

The color of the skin affected with this eruption was unchanged, nor was the peripheral integument altered by inflammation-exudates or oedema. The bullæ were of a dark purplish shade when fully developed, this hue being most distinct about the sides of each. There was no areola of redness about the base of any. The smaller lesions were yellowish and reddish-yellow in color.

In many of the larger and a few of the smaller lesions, there was an appearance which suggested umbilication. This in some instances amounted merely to an apical flattening, and was without question in all cases due to the collapse of the roof-wall upon the shrunken contents of the enclosing chamber. This feature, especially when distinguishable in the lesions of a vesicular or pustular type, strongly suggested the similar eruptive symptoms of varicella and certain forms of variola. It was clear, however, that in the case of these smaller lesions they were no longer in process of development. As compared with those which were evidently more mature, all seemed alike to have been arrested in their course after each had attained its greater or less size.

On the 7th of July I enjoyed a final opportunity of examining this patient. At that date the lesions had naturally much changed in appearance. The eruption as a whole was much less prominent and its earlier characters much less pronounced. Still, here and there over

the originally affected surfaces were to be seen relics of large-sized bullæ, distinct in outline, though otherwise changed. For the most part the lesions remaining evident were dark brownish-colored scabs, made up of the desiccated roof-wall of the pre-existing pemphigoid lesions, without traces of desiccated or otherwise altered exudation. These crusts were firmly adherent to the surface beneath, which seemed to be a base constituted of a more or less solid tissue resembling the flattened syphilitic condyloma. When removed, they disclosed a granulating surface beneath, without the interposition of a purulent or other pathological fluid. The general condition of the little patient had also in the mean time greatly improved. There had been but little loss of flesh, which was the more noticeable as the temperature was unusually high, and the child, while dentition was in progress, had an extensive eczematous trouble upon the scalp.

At the conclusion of my first examination of this patient I recorded the case as one of eczema of the face and scalp, for the relief of which the iodide of potassium had probably been administered, with the result of producing a pemphigoid rash. In the present state of our knowledge, and especially since the publication of Dr. Duhring's similar case, I feel confident that such would have been the prompt diagnosis of all who have studied the literature of the subject. To this source only could I refer, as I had never before enjoyed the opportunity of studying this particular one of the several rashes which the potassium iodide is capable of producing. Soon after this date, in an interview with the attending physician, he admitted, in response to my questions, that for four weeks prior to the appearance of the intercurrent skin disease the child had taken daily 0.30 gm. of the iodide of potassium, which had been intended for the relief, not of the eczema, but of the numerous boils which succeeded to the former trouble. The remedy had been suspended at the time of the appearance of the bullæ, though the doctor had not suspected that the two stood in the relation of cause to effect.

The number of recorded cases in which this accident has occurred is sufficient to establish the origin and identity of this eruption, and to justify certain deductions respecting its natural history.

As far as known to me, the literature of the subject consists of papers by Bumstead, of New York (*Amer. Journ. of the Medical Sciences*, July, 1871, p. 99); the Boinet-Cazenave cases, cited by Bumstead (*Iodothérapie*, 2d, 1865, p. 68); a paper by Dr. Tilbury Fox, of London (reprint from "The Clinical Society's Transactions," vol. xi., 1877); the observations of an anonymous reviewer in the *Edinburgh Med. Journ.* for August, 1873, cited by Dr. Fox; reports from the practice of Mr. Hutchinson, of London (*vid. "Clinical Society's Transactions,"* 1875, vol. viii., and also "Report of the Medical and Surgical Registrars of the London Hospital" for 1875); with a clinical lecture by Dr. Duhring, of Philadelphia (*The Med. and Surg. Reporter*, August 4, 1877, p. 89); a report of cases treated by Dr. R. W. Taylor, of New York (ARCH. OF DERMATOLOGY, April, 1877, p. 227); a case recorded in the service of Dr.

F. N. Otis, at the Charity Hospital, New York (*N. Y. Med. Record*, March 8, 1879, p. 225);\* and a paper by Dr. J. M. Finny, of Dublin, read before the Dermatological Subsection of the British Medical Association (*Brit. Med. Jour.*, Aug. 23, 1879, p. 291).†

Respecting the rarity of this eruption, it may be remarked that Dr. Fox, at the date of writing his paper, was in position to say that Mr. Lane, Mr. Berkely Hill, Mr. Alfred Cooper, Mr. Coulson, and Profs. Hardy, Bazin, Guibout, and Fournier had never seen a bullous or pemphigoid eruption which could be attributed to the drug. And Dr. Bumstead relates that, in the article written by H. E. Fischer, of Vienna (*vid. L'Union Médicale*, January 31, 1860, from the *Wien. Med. Wochensch.*), devoted especially to the eruptions produced by the iodide of potassium, no mention is made of the rash here considered.‡

A chromo-lithograph of about the size of an octavo page accompanies Dr. Fox's paper, and represents well in outline the lesion observed by me. Had a few more stones been used in the production of this plate, giving the purplish shades seen by me, more especially at the sides of the bullæ, the portrait would fairly represent also the colors of the larger lesions I have described. Plate numbered 33, in the Sydenham Society's series, entitled "Hydroa from the Iodide of Potassium," in no way suggests either the eruption figured by Dr. Fox or that described by me.

In the following table I have placed side by side (for the purpose of comparison) the salient features of the various cases detailed by the authors named above :

\* I am indebted for my record of this case to the kindness of Dr. P. B. Porter, of New York.

† See this issue of ARCHIVES, page 404.

‡ In a note from Prof. White, of Boston, received since these lines were written, am informed that he has never seen the eruption here described.

No. of Case.	Author.	Sex.	Age	No. of Attack.	Total Amount of Iodide of Potassium Administered.	Disorder for which the Drug was Prescribed.	Interval between Administration and Appearance of Eruption.	Lesion.	Locality of Lesions.
1 Bumstead.	M.	Years. 28	4	5j (4 gm)	Syphilis	24 hrs.	Bullæ.	Back of neck, forehead, face, backs of hands.	
2 Taylor, R. W.	F.	.....	" Less than 5j (4 gm)	.....	.....	.....	Bullæ, followed by ulcers.	Face, forehead, arms, tongue, roof of mouth, gluteal region.	
3 Taylor, R. W.	F.	.....	" .....	.....	.....	.....	Bullæ.	Arms, neck, and legs.	
4 Duhring.	M.	20	1	Gr. v (.30 gm).	Eczema	4 hrs.	Vesicles, bullæ.	Backs of hands, backs and sides of fingers, one wrist (inner surface), flexor and extensor surfaces of forearms, groins, and pubis, thighs, backs of feet, ankles, toes.	
5 Fox, T.	M.	27	" 5ij (12 gm).	Syphilis	24 hrs.	Large vesicles.	Forehead, eye lids, face, scalp, nape of neck.		
6 Fox, T. (Broadbent).	F.	39	" 5j (4 gm)	.....	5 days	Bullæ.	Forehead, backs of hands, under lip, side of nose, backs of arms, elbows.		
		2 at.	39	2 5j (4 gm)	.....	5 days	Bullæ, followed by ulcers.	Sides of nose, cheeks, forehead, arms, hands, legs, tongue.	
7 Hyde.	F.	8 mos.	1 5ij (8 gm).	Eczema	3 wks.	Bullæ and vesicles.	Arms, forearms, hands, palms, interdigital spaces, backs of hands, wrists, nates, thighs, legs, ankles, feet, and between the toes.		
8 Hutchinson.	M.	26	" .....	Syphilis	.....	Bullæ, pustules.	Face, arms, legs, body.		
9 Hutchinson.	...	.....	" .....	.....	.....	Vesicles.	.....	.....	
10 "									.....
11 "									.....
12 "									.....
13 Anon.	...	.....	" .....	.....	.....	Bullæ, vesicles.	.....	.....	
14 Cazenave.	...	.....	" .....	.....	.....	Bullæ, followed by ulceration.	.....	.....	
15 Otis.	F.	Adv'd age.	1 .....	Syphilis	.....	Pustules and bullæ.	Forehead, face, hands.		
16 Finny.	...	.....	" Increasing doses for weeks.	.....	.....	Vesico-pustules and erythema.	Trunk.		

Color of Lesion.	Contents of Lesion.	Size of Lesion.	General Condition of Patient and Concomitant Symptoms.	Interval after Discontinuance of Drug to Disappearance of Lesions.	Fatal Cases.	REMARKS.
Reddish or purplish.	Clear to turbid serum, blood.	Very large.	Cachexia.	A few days.	.....	Skin about lesions red and oedematous.
.....	Sero-pus, blood.	.....	Sick, tongue swollen, fever.	.....	.....	Intense cephalgia. Alarming symptoms, swelling of face, mouth, and pharynx.
.....	Blood.	Large.	Chills and itching of the skin.	A few days.	.....	Appearance of having been produced by burn.
Pale, yellowish-white, and glistening.	Clear serum, no pus.	Pin-point to large pea.	Good.	4 or 5 days.	.....	Septa, boiled sago-grain appearance. No oedema. One lesion in centre of palm.
.....	Milky fluid, thin pus, inodorous.	.....	Cachexia and 3 to 4 feebleness.	.....	.....	
Yellowish scab.	Turbid serum, grayish pus.	Three-penny piece.	Pleurisy, pericarditis, sore mouth.	5 to 6 days.	1. Chronic Bright's Disease.	Painful.
.....	Sanguinolent and purulent.	Large.	Sore mouth.	6 to 8 days.	.....	
Dark - purple.	Serum, seropus, gelatinous mass.	Pin-head to pig-egg's egg.	Fair general condition; eczema.	A few days.	.....	Quasi-umbilication.
Purple and red.	Thin, yellow, offensive.	1/4 to 1/2 in. high.	.....	18 days.	1	Inflamed areola.
.....	.....	Shot, cherry.	.....	.....	.....	No umbilication; depressed centre.
.....	.....	.....	Fever, distress.	.....	.....	Umbilication.
.....	Serum, blood.	.....	.....	.....	.....	Lesions readily torn.
.....	.....	Large.	Marked cachexia; extensive superficial ulcerations of surface of extremities.	1 week.	.....	Some pustules, distinctly umbilicated.
.....	.....	Small shot to split pea.	.....	6 days.	.....	.....

A study of the cases tabulated above suffices to establish the following facts:

The eruption has been recorded by the authors named as occurring eighteen times in fourteen individuals. Of nine patients, whose sex is stated, four were males and five females.\* The youngest patient is she whose case I have described,—one which, for that reason, has an especial interest in this connection,—an infant at the breast, 8 months old. The age of the eldest of those whose age is given was 39 years. In two cases, the eruption recurred in each individual; once in a second, and once in a fourth attack. The quantity of the drug recorded to have been ingested, varied from 0.30 grammie to 12 grammes. In a few instances the medicament was continued after the production of its toxic effects, in consequence of a failure to recognize their import. Four times the remedy was administered for the relief of syphilis; twice in the treatment of eczema. The period which elapsed between the administration of the last dose and the explosion of the cutaneous symptoms varied between four hours and five days.

By ten writers the lesions are described as "bullous," five adding the term "vesicle;" two adding the word "pustule;" in one case only is the eruption said to be constituted only of "large vesicles;" once, of "vesico-pustules."

As regards the localities affected by the eruption, we find that it was observed twenty-one times upon the different portions of the head and neck; twenty times upon the upper extremities; twelve upon the lower; and but six times over the surface of the trunk. To enumerate these localities more precisely, we find six observations of the disease on the forehead; five on the face; two on the sides of the nose; two on the tongue; one on the cheeks; one on the eyelids; one on the under lip; and three on the back of the neck. Eight times it was noticed on the arms and forearms; once on the hands; six times on the backs of the hands; twice on the backs and sides of the fingers; twice over the wrists; and once only over the elbows. Twice the bullæ appeared over the general surface of the body; twice over the nates; and once over the groins and pubis. Four times the legs were affected, and twice each the thighs, ankles, feet, and toes.

The lesions, which were generally described as bullæ, began either as, from the first, pin-point-sized vesicles, or as shot-like papules, at the apices of which vesiculation subsequently occurred. These in color were pale yellowish-white, and glistening. In some instances, where only a small dose of the drug had been administered, or where it had been promptly discontinued on the appearance of toxic effects, the subsequent evolution of symptoms was not decided. Where, however, the dose had been large, or persistently continued, and especially when there had been coincident cachexia, subsequent changes were noticed in the eruptive phenomena. In color the bullæ became successively red, dark-red, purple, and dark-purple. Containing at first merely a clear and limpid serum, the

contents of the lesions changed to a thin sero-pus, inodorous, and sometimes almost creamy. To this succeeded a pure yellowish pus, which, in cases, degenerated to a sanguinolent ichor, of foul odor. In a few instances blood only was found in the pemphigoid lesions at an early stage.

The existence of the toxic phenomena is in cases compatible with the enjoyment of fair health. This, at least, was noted in two instances. In four there was a record of cachexia and prostration; in one the patient suffered from chills. Two fatal cases are recorded; one from chronic Bright's disease, with pleuritic and pericardial complications. In the case of the other patient the history is indefinite. It seems clear, however, that the result was due rather to the depraved general condition of the patient than to either the remedy or the eruption produced by it. It should be remembered in this connection that the greater number of patients displaying this form of cutaneous disease will always be those in whom the effects produced by the drug are partially masked by the disorder for which the drug is prescribed. There is no reason to believe that in those depressed states of the system where the bullæ have been noted, for example, upon the mucous surfaces of the roof of the mouth and the tongue, the cachexia is immediately and solely due to the action of the iodide of potassium.

Upon one point all the authors are agreed, viz., that in a few days after the drug is discontinued, the eruption disappears, even in cases where there is great cachexia. Eight days at the longest have sufficed to greatly improve the cutaneous symptoms, the patient in one case dying over two weeks after the eruption first appeared.

Upon two points there is a discrepancy between those who have reported cases. One of these concerns the inflammatory areola, which, in certain patients, has been seen surrounding the individual lesions, and in others has been absent. The other relates to the umbilication of the bullæ. This has not been observed by the greater number of authors; and I am inclined to believe that in those cases where it has been seen, the phenomenon was due to the shrinkage of the roof-wall of the lesion upon its contents.

The late lamented Dr. Tilbury Fox, from the observations to which he had access at the time his paper on this subject was read before the Clinical Society of London, draws some conclusions which can only be accepted with reserve in the light we can command at the present time. He states, for example, that the pemphigoid rash is excited only "under the influence of small and few doses," a conclusion certainly not warranted if the history of my case be accepted as typical of the infantile symptoms. He also declares that "the action of the drug in these cases is not limited to the skin, but produces great depression, with or without pyrexia, ulcerations of the mucous membranes, etc.," a deduction which is manifestly incorrect as applicable to all cases, and one which, as I have attempted to show, may be doubted in all those cases where a depressing disease has existed, for the relief of which the remedy was prescribed.

Lastly, Dr. Fox is of opinion that the eruption is one which originates in the sebaceous glands, and that the contents of the bullæ are altered secretions of the sebaceous glands. Investigation, chemical and microscopical, will of course be necessary to set at rest the problem which he thus presents, but the clinical reasons for dissenting from his opinion seem to me to be worthy of consideration. If the sebaceous glands were the seat of the disease, it would be reasonable to look for its most abundant development in those localities where we are accustomed to find the sites of election of such other sebaceous-gland disorders as milium, comedo, seborrhœa, acne, etc. These sites of election, it need not be said, are the face, the scalp, the back of the neck, the back of the trunk, and the genital region. But it has been pointed out above that the pemphigoid rash under discussion, though occurring most often upon the head, has never been reported upon the scalp, and that the region of next preference is the upper extremity, especially over the wrists and forearms, localities which, as Bumstead shows, are exposed to the air, and which, it need not be said, are not regions where we are accustomed to find the sebaceous-gland disorders mentioned above. I desire also to call special attention to the fact that, both by Dr. Duhring and myself, the lesions were observed upon the palms of the hands, where Biesiadecki and others have never been able to demonstrate the presence of either sebaceous glands or lanugo follicles.

Two other clinical considerations should be here mentioned. One is the chronicity which usually characterizes sebaceous-gland disorders, such as acne, comedo, etc., as opposed to the circumstance that the bullæ produced by the iodide of potassium have been seen within five hours after the administration of the drug. The other is the recorded occurrence of blood-contents in the lesions. The transformation of the secretion of a sebaceous gland into a thin odorless or offensively-smelling sero-pus cannot be viewed as beyond the possibility of occurrence; but a sanguineous seborrhœa could be regarded only as the symptom of a formidable constitutional dyscrasia. These and possibly other considerations which might be suggested lead me to the conclusion that, for the present, at least, we are not justified in accepting without reserve the statements relative to the sebaceous origin of the rash which we have been studying.

The most valuable of the practical conclusions to which such a study leads would seem to be: (*a*), that, in eczema, where a distinctively vesicular or bullous eruption becomes suddenly apparent, the lesions intermingled with those characteristic of the disorder named, in the person of patients who have been under the charge of inexperienced practitioners, the possibility that the iodide of potassium has been previously administered should be carefully estimated; (*b*), that it is not only possible but quite probable that the rare vesicular and bullous lesions recorded as occurring in acquired syphilis may be rashes induced by the administration of the iodide of potassium for the relief of the disease.

TWO CASES OF CHANCRE OF THE LIP, PROBABLY ACQUIRED THROUGH CIGARS.\*

BY L. DUNCAN BULKLEY, A.M., M.D.,

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SINCE the fact has been conclusively established that the syphilitic poison may be conveyed by other means than by venereal contact, instances have been reported of almost every conceivable method of communication, including even that by means of tooth-brushes, dental instruments, and toys, as well as by vaccination, circumcision, and tattooing, also in surgical examinations and operations, and from the promiscuous use of implements, as glass-blowers' pipes, etc., etc. With a poison so subtle and powerful, and so abundantly secreted from the many diseased mouths on all sides, and thus so almost omnipresent, the only wonder is that there are so few instances of the non-venereal communication of syphilis. While cases are on record where the poison has been conveyed by means of smoking a pipe used by one suffering from syphilis, I am not aware that any have yet been reported where cigars have been the method of communication. The two following instances are therefore of interest and value, inasmuch as both occurred in educated physicians, who had given very much study to their cases, and therefore the certainty of eliminating other methods of contagion was very greatly increased.

Several years ago a case found its way into the secular newspapers, where a young girl (in Connecticut, I believe) was found to be making cigars while suffering from constitutional syphilis. Her lips were covered with freely secreting mucous patches, and she was in the habit of finishing the cigars by moistening the ends in her lips to make the sharp point; this she continued to do for some weeks, until the severity of the pain caused her to cease and she came under the care of a physician.

A very similar case has been under my care at Demilt Dispensary within the past year. A young man, cigar-maker by trade, consulted me on account of the soreness of his mouth and tongue, which were found to be the seat of very extensive mucous ulcerations, and while he was under observation a very characteristic pustular syphiloderm developed, together with adenopathy, alopecia, etc. Remembering the case of the girl just mentioned, I questioned him in regard to the process of manufacture of the cigars, and he acknowledged to his using his saliva to moisten the end to complete the point. As is well known, this is not the universal method of procedure, and is of course discountenanced by manufacturers, and I believe that gum

\* Read before the American Dermatological Association, New York, August 26, 1879. For discussion, see page 372.

tragacanth or flour paste is provided for the purpose, but I have myself repeatedly seen employés moisten the end of the cigar in the mouth in finishing the tip.

The following are the cases:

*Case 1.*--Dr. J., aged 33, an active practising physician in a neighboring city, consulted me, Oct. 26, 1877, on account of an obstinate sore on the upper lip, which gave him much annoyance. Six weeks previously he first began to notice an ulcer on the left side of the upper lip, on the vermillion surface, and two weeks later the right side became sore. This had persisted since in spite of varied remedies, none of them, however, of an anti-syphilitic character, as the true nature of the diseased surface had not been hitherto recognized, although he had seen a number of physicians around him, and also those in a neighboring city.

On the left side of the upper lip there was an oblong ulcerated patch thirteen millimetres (half an inch) long by eight millimetres (one-third of an inch) wide, with a clean, red surface, secreting a small amount of sticky fluid, and with a very decided hardness. Upon the right side of the lip there was another patch of ulceration, presenting somewhat the same features, rather smaller, with a white patch running from it to the corner of the mouth. There were also mucous patches on the roof of the mouth and on the right tonsil. The submaxillary glands were enlarged and painful, no other adenopathy was found. Upon the arms and back there was already a faint macular eruption. He stated that for the previous two weeks he had been having general rheumatic pains and malaise, and had lost flesh of late. There was absolutely no sore on the penis or elsewhere, nor had he ever had such.

The diagnosis of chancre of the lip was made; at the urgent request of a friend he consulted Dr. F. N. Otis later the same day, who made the same diagnosis, without knowledge of his having seen me previously.

Being a married man, with two children, he was exceedingly anxious in regard to his lip, and much time was spent investigating the possible modes in which the sore might have been acquired. He claimed entire innocence in regard to any venereal origin of the trouble; he certainly had not kissed any one outside of his own family for a long time. Three months previously he had examined a patient with a sore on the penis, and remembered being anxious about a scratch on his finger, but this healed readily and gave no further annoyance. Since that time he had not seen a patient with primary syphilis. He had not smoked a pipe for months, and never smoked that belonging to another, nor was in the habit of having others smoke his.

He was, however, a great smoker of cigars, and had consumed a quantity of those made in this country. Remembering the case of the girl first cited, and considering that there must be other cigar-makers in similar condition, we concluded that the poison had been conveyed by means of the cigars, although, of

course, it was impossible to trace it to the particular source whence it emanated.

He was placed upon half a grain of the green iodide of mercury morning and night; in less than a week the sores showed manifest improvement, and in four weeks, or possibly less, every trace of them was gone. The rheumatic pains ceased at once and he gained in flesh and strength.

*Case II.*—Dr. F., aged 40, consulted me, July 4, 1879, for a sore situated in the middle of the lower lip, which gave him considerable annoyance and refused to heal. The history was as follows:

For ten or fifteen years he had had a fissure in the middle of the lower lip, which, while it would sometimes heal over for several weeks, would still persist as a crack of greater or less size: it had never before taken on any ulceration or given any great annoyance other than that incident to such a fissure.

Six weeks previous to his visit he noticed that the fissure was more painful, and that it discharged serum, which it had never previously done, however much irritated, and he was obliged to wipe it off frequently. Two weeks later the glands beneath the right angle of the jaw became enlarged, and subsequently those in front, beneath the jaw.

Recognizing a new feature in his lip-trouble, and fearing lest in some manner he had acquired syphilis, he applied freely a solution of chromic acid, one hundred grains to the ounce, very soon after he noticed the secretion. Some days later he cauterized it with nitric acid, and began to take a little bichloride of mercury and iodide of potassium. The applications but irritated the lip, and it did not heal, and he was persuaded by a number of physicians who saw him that the sore was not syphilitic, and discontinued the internal medication. Three weeks later, June 15, it had reached its greatest size, that of a large thumb-nail, the lip was swollen, hard, and painful, and the glands under the right angle of the jaw made a mass as large as a goose-egg. He then began treatment again, and in a week the ulcer began to close in on the edges.

Three weeks previous to his visit, and just before commencing the specific treatment the second time, he discovered a small ulceration on the penis, which healed readily after cauterization with nitric acid. This was probably due to inoculation from the sore on the lip, which had been greatly irritated by the ineffectual efforts to heal it by means of the chromic and nitric acids.

About ten days previous to his visit, and when the lip began to heal under treatment, an eruption made its appearance, first upon the scalp, then on the forehead, and spread thence over the face and most of the body and limbs. Three or four weeks ago, before commencing treatment the second time, he had feverishness and malaise and could not sleep.

On examination the lower lip was found to be the seat of an ulcerated mass of nearly circular form, about thirteen millimetres (half an inch) in diameter, situated a little to the right of the median line,

with a distinctly marked margin, now healing ; it had a granulating base, giving off a serous secretion, and bleeding quite readily. There was no great amount of hardness, as he had been under mercury for some time, and the swelling of the lip had largely gone. There was still marked adenopathy, both at the right angle of the jaw and in the middle beneath. The face was thoroughly sprinkled with a most characteristic papulo-erythematous eruption of syphilis, with more or less of the same in the scalp and scattered over the entire body and limbs.

No doubt could be entertained in regard to the diagnosis, and the sore on the lip was unhesitatingly pronounced a chancre, although the doctor was utterly unable to account for its presence. Although in times past he had lived a somewhat free life, he certainly had not had any venereal exposure for many, many months. He had certainly not smoked any one else's pipe, nor had any one smoked his, which he used very seldom. He was, however, a considerable consumer of cigars, and upon questioning narrated a circumstance which might have a very important bearing on the case.

About three months previous to his visit he had had as a patient the son of a cigar-maker, with sores on the penis. In gratitude the young man would, from time to time, hand him cigars of a very fine quality, desiring him to smoke them. At the time he thought of the danger of contagion, and is of the impression that he smoked them in a cigar-holder, but of this he is not positive. Very careful investigation failed to reveal any other possible or probable means of acquiring the chancre, the patient being a physician of uncommon intelligence and clearness, and we were forced to the conclusion that the poison was conveyed on the cigars, possibly transferred from the patient's hands, or possibly lodged there in process of manufacture by the patient or other person. In conversing with a large manufacturer of cigars upon this subject, he expressed himself as not at all surprised that such inoculation should take place, for he said that those employed in making cigars were of the dirtiest class, and were continually in the habit of putting the fingers to the mouth during their work ; also not being at all careful to wash, that they could readily convey the poison from the genital parts to the cigars which they manufactured.

It is not long since the existence of syphilis in a patient was sufficient to condemn him of unlawful sexual intercourse, and many have doubtless been thus falsely charged who were as innocent in the matter of contracting the disease as are those who acquire the smallpox instead of the pox proper. Each additional method of communicating the disease which is demonstrated, therefore, lightens by at least one stone the crushing weight which would otherwise rest upon every unfortunate sufferer from this dire malady if it were supposed that it could be acquired only by venereal contact.

On the other hand, the knowledge that so potent and terrible a poison exists so extensively, and that it may attack the most inno-

cent, as in vaccination or nursing, or even in the unsuspecting kiss of a near relative, or in the quiet enjoyment of a cigar, should put both the profession and laity greatly on their guard, and should place syphilis among the contagious diseases which should be under the surveillance of the officers of the public health. It should also cause the wilful or careless propagation of the disease to be placed among punishable crimes.

The methods of prophylaxis in reference to contamination through the medium of cigars are self-evident. The careful use of the holder will prevent the catastrophe, or the same may be accomplished by enveloping the end of the cigar in a bit of paper; but even the process of wetting it for either of these might convey the poison from a cigar well charged to a fissured lip, or to one affected with cold sores or abrasions. Care should therefore be exercised, especially when such avenues of entrance exist.

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#### ABSTRACT OF A PAPER ON MICROSCOPICAL STUDIES ON INFLAMMATION OF THE SKIN.\*

BY C. HEITZMANN, M.D.

WHEN looking over the history of the doctrine of inflammation in general, we are struck by the fact that since the time of the use of the microscope repeated revolutions have occurred. In the fifth decade of our century, the so-called "humoral pathology" being the leading doctrine,—its founder, the late C. Rokitansky, of Vienna,—the whole process of inflammation was thought to be caused by an anomalous mixture of the blood, and to run almost exclusively in the vascular system. Even the newly-formed elements, the so-called "exudation- and pus-cells," were considered as products of the fluid exudation, almost nothing being known about the changes in the inflamed tissues themselves. At that time the process of inflammation was demonstrated with low powers of the microscope on the web-membrane of the frog. In the sixth decade the "cellular pathology" became the leading doctrine, its chief representative being R. Virchow, of Berlin. This doctrine neglected the blood-vessels and the product therefrom, viz., the exudation, to such an extent that, based upon observations on the cornea and the cartilage, on which non-vascular tissues inflammation could be produced, the blood-vessels were thought to be irrelevant elements of the process of inflammation. In the seventh decade I. Cohnheim, of Leipsic, arose with the assertion, based upon observations on the mesentery and the tongue of the frog, that the course of inflammation depends almost exclusively upon emigration of the colorless blood-corpuscles

\* Read before the American Dermatological Association, New York, August 26, 1879. For discussion, see page 376.

through the blood-vessels (capillaries and small veins), while the so-called cells of the tissues simply perish. In this view all newly-appearing elements, the inflammatory new formation and the pus-corpuscles, were emigrated blood-corpuscles.

Each of these leading doctrines had in its time a crowd of followers and believers. Rokitansky himself in turn adopted in its main features the cellular pathology, which holds good even in our days for the majority of the pathologists, so much so that the emigration theory in its full perfection was taken up by but a few observers, some of whom, however, admit that, besides the colorless blood-corpuscles, also the "cells" of the tissues share in the inflammatory process.

Towards the end of the last and the beginning of the present decade of our century S. Stricker, of Vienna, was the strongest opposer to the emigration theory, asserting that in each of the former doctrines there was a partial truth. Stricker studied inflammation mainly on the cornea, and the conclusions he arrived at were that the blood-vessels and nerves are necessary ingredients to the inflammatory process, that the inflammatory new formation is almost completely a product of the "cells" of the tissues and their offshoots, and that the emigration of colorless blood-corpuscles is beyond the proof of our present methods of observation, so far as its participation in the inflammatory new formation is concerned. Stricker was the first to prove the correctness of the hypothesis of John Hunter, that the essential change of an inflamed tissue consists in its reduction to a juvenile, embryonal condition.

Such was the standing of the doctrine on inflammation when I took up its study in 1872, in Vienna. I chose first cartilage, which is by no means a non-vascular tissue, as was thought in former times, but is provided with medullary spaces, which hold a complete vascular system, though in relatively great distances from one another, in such a way that large territories of the cartilaginous tissue are devoid of blood-vessels. Next I studied bone, which is fit for this purpose far better than any other tissue, and by and by I extended my observations over pretty nearly all tissues and organs of the animal body, including also the complicated organ, termed skin. The results of these observations are laid down in a number of publications, both in German and English, partly originating from gentlemen of the medical profession who worked in my laboratory under my surveillance. I can fully corroborate the assertions of S. Stricker, above quoted. At the same time I stepped forward and farther than any investigator did before, so much so that I venture to say the inflammatory process is perfectly plain to-day in its minutest features, so far as our best modern microscopes allow of a definite conclusion. More than that, the present results of researches are in full accordance with clinical observation,—an accordance which was impossible with all former doctrines. My researches also explain the constitutional influence upon the inflammatory process in a quite satisfactory way.

Let us briefly recapitulate the minute anatomy of the two main tissues entering the structure of the skin, viz., epithelium and connective tissue. Each fact has been demonstrated for nearly five years to a large number of attendants of my laboratory, and proved by numerous observations on those tissues both in their normal and morbid conditions.

The epithelium represents a continuous layer of living matter on the surface of the body, and on all cavities and elongations which are in direct or indirect communication with the outer surface. The elements of this layer are protoplasmic bodies, flattening one another; separated from one another by a cloak of horny cement-substance, and uninterruptedly united with one another by means of delicate spokes traversing the cement-substance, the formerly so-called "thorns." The living matter, which produces a delicate reticulum in each protoplasmic body,—its points of intersection being termed nucleoli, nuclei, and granules,—traverses the cement-substance in the shape of "thorns," and thus produces the continuity all through the living layers of the epithelial elements, as well as with the underlying layers of the connective tissue. Epithelium is devoid of blood- and lymph-vessels; but, where it is living, it is supplied with a large amount of nerves, which in the shape of very minute, beaded fibres run through the cement-substance, and are here in direct connection with the fibrillæ of living matter; indirectly, therefore, with the reticulum of the living matter within the protoplasmic bodies themselves. Delicate excavations in the cement-substance, analogous to the well-known bile-capillaries in the liver, and evidently destined to carry the nourishing material to the epithelia, have been recently discovered by Arnold, of Heidelberg.

The connective tissue entering the structure of the derma is made up of bundles of fibres, which, through manifold decussations, produce a very dense feltwork, coarsest towards the subcutaneous fat-tissue and finest in the outermost, so-called papillary layer of the derma. The main directions in which the bundles of the fibrous connective tissue cross one another on different portions of the skin have been accurately studied by C. Langer, of Vienna, and Tomsa, of Kiew. The bundles are bounded in many instances by a very dense basis-substance, representing the elastic fibres, and separated from one another by narrow layers of a cement-substance (Tomsa) which in its chemical features is kindred to the glue-giving basis-substance of the fibrous connective tissue in general. In this cement-substance there are imbedded delicate formations of protoplasm, greatly varying in amount in the derma of persons of different age. They represent formations analogous to nuclei, formerly so-called "connective-tissue cells," at present considered as compact masses of living matter; or delicate, reticular layers of living matter, which, with a power of five hundred diameters of the microscope, look finely granular. The whole glue-giving basis-substance of the bundles is traversed by a delicate reticulum of living matter, in direct union with all protoplasmic formations between the bun-

dles, with all blood- and lymph-vessels, with all nerves, and with the columnar epithelia nearest to the papillary layer. The reticulum of living matter, which I first discovered in 1873, is invisible in the fresh condition of the connective tissue or in specimens obtained after hardening in alcohol or chromic acid solution, owing evidently to the refracting power of the basis-substance; but can be brought distinctly to view through staining methods, such as nitrate of silver stain in a negative, and chloride of gold stain in a positive way, and through observation in all instances when the refracting power of the basis-substance is increased (deposition of lime salts) or decreased (liquefaction, dissolution) in different normal and morbid conditions of the connective tissue. Only the meshes of the network of the living matter contain the glue-giving basis-substance which, as the history of development of the connective tissue demonstrates, is produced by a chemical alteration of the lifeless protoplasmic fluid itself. The bundles of the connective tissue of the derma accompany all elongations of epithelial nature; the bundles produce the follicle around the root-sheaths of the hair, the capsule around the sudoriparous glands, the accompanying layers around their ducts. The bundles of connective tissue are traversed in oblique direction by bundles of smooth muscle-fibres, *viz.*, the arrectores pilorum, the numerous muscle-bundles in the derma in and around the nipples, the scrotum, and the labia majora. The connective tissue, furthermore, is traversed by relatively scanty blood-vessels in the derma, by numerous capillaries in the papillary layer, by lymph-vessels, which produce a perfectly closed system, as brought to evidence by Teichman, of Cracow, and Sappey, of Paris. Lastly, numerous nerves run through the connective tissue, both of the medullated and non-medullated variety. The former mainly produce the tactile corpuscles within the papillæ; the latter, being partly sensitive, terminate in the epithelial layer; partly motor, terminating in the bundles of smooth muscle-fibres; partly vaso-motor, spun around the blood-vessels (Tomsa); or secretory and trophic, supplying the sebaceous and sudoriparous glands and all protoplasmic formations of the skin. About the termination of the latter varieties of the nerves almost nothing is known.

The process of inflammation of the skin I have studied on specimens from a syphilitic papule, from smallpox, from an ulcerating sac of the umbilical rupture of a cat; also in its terminations on specimens of elephantiasis of the scrotum and the labia majora, as an accompanying process on the skin of the female breast in mastitis and cancer, on the skin covering different benign and malignant tumors, or directly engaged in the formation of such tumors, all types and varieties of which are represented in my collection. The results being almost identical in regard to the essential changes in the tissues of the skin, I can confine myself to the description of the inflammatory process in smallpox, of which I obtained six different specimens from the Blackwell's Island Hospital, among these two of hemorrhagic smallpox. In these specimens there are

represented all stages of the disease in the most satisfactory manner.

The coarser microscopical relations in the formation of smallpox have been accurately studied by Auspitz and Basch, of Vienna. The minute features observable with high magnifying powers of the microscope—800 to 1200 diameters—only, and based upon the knowledge of the normal anatomy of the engaged tissues, are as follows :

First, the epithelial layer, termed *rete mucosum*, appears slightly thickened on circumscribed spots; the swelling is due to a coarse granulation of the epithelia themselves. The coarse granulation is produced by an increase of living matter within the protoplasmic bodies, evidently through an augmented afflux of nourishing material in the stage of hyperæmia. The points of intersection of the network of living matter, formerly so-called granules, become enlarged, many of the nuclei shining and solid, and at the same time the threads traversing the cement-substance, the formerly so-called thorns, become thickened. The underlying papillæ are slightly enlarged in all diameters, partly owing to a dilatation and engorgement of their capillary blood-vessels, partly to a peculiar change of the bundles of the connective tissue and the protoplasmic bodies between them. The latter look slightly enlarged, and in many instances coarsely granular; the former are partly transformed into protoplasm. In other words, where before there were present bundles built up by a glue-giving basis-substance, at present the reticulum of the living matter, formerly hidden in the relatively solid basis-substance, become visible again, through a liquefaction or dissolution of this substance. No other proof of the presence of an exudation in this stage is obtainable, except the liquefaction of the gluey basis-substance. This stage of the inflammation is termed “papular.”

Next in the midst of the papule, on one or on several spots, the exudation makes its appearance; the outer or epidermal layer at no time participates in the morbid process. In some epithelia we notice an enlargement of the meshes of the living reticulum; the latter is first stretched, afterwards torn apart, the granules being now suspended in the liquid exudation. Where there were present epithelia before, a small, irregular cavity is visible. If several such cavities had formed in a papule, through a continuously increased accumulation of the exudation and destruction of the epithelia, the separating layers of the epithelia become compressed and produce septa, traversing the cavities. Such septa are greatly varying in number and width. The neighboring epithelia look very coarsely granular; many of them have lost the enclosing cement-substance, and are thus transformed into protoplasmic clusters, in which, through a considerable increase of the living matter, new shining lumps of different sizes have appeared, still in continuity with the neighboring reticulum, by means of delicate threads,—the so-called endogenous formation of new elements. The result of this process is the forma-

tion of an irregular cavity in the midst of the greatly-widened rete mucosum, traversed by septa of compressed epithelia; filled with an exudation, in which there are suspended numerous delicate granules, generally termed coagulated albumen, and a varying amount of irregular threads in the shape of a feltwork,—the coagulated fibrin. Scanty protoplasmic bodies are suspended in the exudation also; perhaps remnants of the destroyed epithelia, perhaps immigrated inflammatory or colorless blood-corpuscles.

In this condition of the rete mucosum, also, the underlying connective tissue exhibits considerable changes. The papillæ have disappeared, evidently through the pressure from above; the transformation of the connective tissue into protoplasm has advanced in some instances to such a degree that the uppermost layers of the derma are replaced by numerous indifferent or inflammatory elements, as a rule clustered together. All these elements, however, are in uninterrupted connection with one another, through delicate threads of living matter, fully analogous to those of the epithelia; and thus the inflamed tissue, though reduced into its medullary condition, still represents a tissue. The stage of the disease in which the changes just described have taken place, is known as the vesicular stage of smallpox.

Lastly, pus-corpuscles appear in the cavity within the rete mucosum, which doubtless arise in their main mass from the epithelia traversing and bounding the cavity. Through the increase of living matter in a large number of epithelia shining lumps appear: first homogeneous, afterwards through the intermediate stage of vacuolation transformed into nucleated protoplasmic bodies, with a fully-developed reticulum of living matter,—the pus-corpuscles. The main source of pus-corpuscles, therefore, are the epithelia themselves, the endogenous new formation. How many of the pus-corpuscles have appeared through an immigration from below, from the inflamed connective tissue or from the blood-vessels, nobody can tell. The immigration is a sensible hypothesis only, without direct proof or foundation; while the endogenous formation can directly be traced in all its stages. The pus-corpuscles look coarsely granular,—viz., are supplied with a large amount of living matter on the points of intersection of the living reticulum in persons of a good, strong constitution; on the contrary, they are finely granular—that means, scantily provided with living matter—in persons of a weak, so-called scrofulous or tuberculous constitution, or in persons debilitated by different acute or chronic diseases. In the former instance the pus is thick and yellow; in the latter instance watery, serous, and pale. The subjacent connective tissue in many instances does not advance beyond its reduction into a medullary tissue. In some cases, however, also the newly-appeared and newly-formed medullary elements, which produce the infiltration of the derma in a varying depth, are torn asunder, and thus represent pus-corpuscles, which commingle with the pus arisen from the epithelia, and share in the formation of the abscess.

This stage of the inflammation is known by the term pustular stage of smallpox, and represents the typical termination of the whole process. The pustule either bursts or its contents dry up and produce a crust. As long as the inflamed derma remained in the condition of a medullary tissue,—as long, therefore, as the medullary or inflammatory elements remain connected with one another,—the re-formation of a glue-giving basis-substance in the shape of bundles of fibrous connective tissue will be accomplished without the formation of a scar. If, on the contrary, a part of the connective tissue has been transformed into pus and thus completely destroyed, the result will be a cicatrice. Mere epithelial suppuration heals *without*, suppuration of the connective tissue always *with*, the formation of a scar. The pigmentation of the skin, so common after smallpox, is due to the imbibition of the coloring matter of the red blood-corpuscles by the reticulum of living matter in the epithelia; or by changes of directly extravasated red blood-corpuscles both in the rete mucosum and the derma. Such extravasations occur in all severe cases of smallpox; in the highest degree, of course, in hemorrhagic smallpox.

My observations on inflamed portions of skin have led me to the following conclusions:

1. In epithelium the first step of the inflammatory process consists in an increase of the living matter both in the protoplasmic bodies and between them; the former produces the coarse granulation of the epithelia, the latter the thickening of the so-called "thorns" in the cement-substance. Any particle of living matter, both in the epithelia and between them, through continuous growth, may lead to a new formation of epithelial elements, with the termination in hyperplasia of epithelium (psoriasis, squamous eczema, horny formations, etc.).
2. In connective tissue the first manifestation of the inflammatory process is the dissolution of the basis-substance and reappearance of the protoplasmic condition. By this process and the new formation of medullary elements, which may start from any particle of living matter, the inflammatory infiltration is established. The sum total of the inflammatory elements, which remain united with one another by means of delicate offshoots, represent an embryonal or medullary tissue. If the new formation of medullary elements be scanty, the resolution is accomplished by re-formation of basis-substance (erythema, erysipelas, etc.). If, on the contrary, the production of medullary elements be profuse, a new formation of connective tissue will result,—hyperplasia (scleroderma, elephantiasis, etc.).
3. The plastic (formative) inflammation may be accompanied by the accumulation of a larger amount of a serous or albuminous exudation in the epithelial layer (miliaria, sudamina, herpes), or in the connective tissue of the derma (urticaria). In both instances complete resolution will ensue.
4. Suppuration in the epithelial layer of the rete mucosum is produced by an accumulation of an albuminous or fibrinous exudation,

by which a number of epithelia are destroyed, and by new formation of pus-corpuscles from the living matter of the epithelial elements themselves. Epithelial suppuration heals without the formation of a cicatrice (eczema madidans and pustulosum, impetigo, pemphigus, variola).

5. Suppuration in the connective tissue of the derma results from the breaking apart of the newly-formed medullary elements, which, being suspended in an albuminous or fibrinous exudation, now represent pus-corpuscles. Pus is a product of the inflamed connective tissue itself, and always a result of destruction of this tissue. Suppuration of the derma invariably heals through cicatrization (abscess, furuncle, acne, ecthyma, variola).

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## TATTOOING OF NÆVI.\*

BY S. SHERWELL, M.D.,

Clinical Professor of Dermatology in the Long Island Medical College, etc.

ON February 13, 1877, at a meeting of the New York Dermatological Society, I read a paper with the above title,—afterwards published in vol. iii. page 214 of the ARCHIVES OF DERMATOLOGY,—giving accounts of successful operative procedures of this nature in a few cases. The present paper and case I would wish to be regarded as supplementary only to the one published, knowing that the ARCHIVES must be in the hands of most, if not all, members, and can be referred to; the “*rationale*” and method of treatment remain substantially unchanged.

Since the time mentioned the number of cases coming under my hands has, unfortunately, been very limited, and their nature and extent have rendered them very unpromising. I have, however, to present to this Association to-day a case in which the merits of the operation are fairly shown, and where the benefit has certainly been very great. It illustrates, too, various points, as to the necessarily long duration of treatment, etc.

Miss E. L. came to my office September, 1877, with a nævus of a dark-claret color—the orthodox port-wine stain—which involved the whole chin, extending as it did from a line transversely across the face, occupying the whole of the vermillion border of lower lip and extending on each side nearly as far as the course of the facial artery in that part of the face. The inferior aspect of the chin was also involved to a nearly, but not quite, corresponding area. Like the majority of these deformities, it was not quite circular in outline, and of well-defined figure; but there were peninsular

\* Read at the third annual meeting of the American Dermatological Association, August 27, 1879. For discussion thereon see page 382.

prolongations running out here and there, also on centre of the left cheek a well-defined dark stain about an inch—rather more than less—in diameter, the remnants of which may yet be faintly seen.

These marks, loud-colored and obtrusive as they were, on a face otherwise prepossessing, were naturally a source of great annoyance to her, and she had also found them of pecuniary injury in the following manner: having been reduced from comparative affluence to be obliged to accept a position as saleswoman in a dry-goods store, her unfortunate blemish was the cause of her removal, owing to lady customers, having somewhat natural fears in the matter, who had remonstrated. So, greatly to her own and her employer's regret, she was forced to leave that position. I leave the members to judge if that would be possible now, always conceding, however, that at best some slight blemish will remain.

The patient, during the eighteen months subsequent to September, 1877, has been tattooed over the whole surface (with exception of a spot on the cheek, cured in one operation) twice, at intervals of months, once with chromic, once with carbolic acid, dilute; other couple of times comparatively smaller areas of the worst remaining parts have been selected and operated upon. The last operation was about seven months since. I have purposely postponed another, which I hope will be very effective, till October or November next, having wished to show the case before the Association, and also to take advantage of the cooler weather, which allows the collodion coating to remain on and exercise its contractile force longer when the perspiration from beneath is comparatively absent, also as being at such a time less obnoxious to the patient.

While, then, this mode of treatment is neither painless, instantaneous in results, nor, as I once claimed, never leaves a scar (it sometimes does,—a small flattened one, as you may observe), I think it has advantages over all other methods with which I am at present acquainted. Certainly the method recommended by Mr. Balmanno Squire has been unsuccessful, as far as I can learn, in the hands of those in New York who have tried it, and I see no further mention or commendation of the subject from his or any other pen in the periodicals.

I have not changed my after-treatment in any marked degree, and still believe in the "*rationale*" of the application of the collodion coat over the freshly-perforated skin, for reasons given in the published article, to which reference has been made, and recapitulation of which I spare you. My styptic applications are the same as those named, and I would in all instances recommend a tentatory or exploratory operation, with somewhat milder applications, as an index for testing the sensitiveness or idiosyncrasy of the patient.

Up to the present time I have been using an instrument of home manufacture (one of which I pass around), but am now having made by Messrs. Tiemann & Co. an instrument which will, as I believe, be neater, more effective, cause less pain, and be easily cleansed.

One or two general remarks before closing. Ordinarily, I judge

that in this manner, as in all others intended for the relief of nævi, the difficulty, or at least the tediousness, of cure is in almost universal proportion to their size; the smaller nævi, as in the case before us (the spot on the cheek), disappear often after one operation. Then, again, the well-known, great difference in sensitiveness of the different parts of the body must be taken into consideration. The slight scarring under the chin in this case was caused by the same strength of application that was applied without anything but benefit to the parts above. Nothing but some experience in this matter can guide.

Parts that are pendulous and soft, as the lips, appear more difficult to operate on, from their resiliency, etc., and do not show so good a result relatively, caused, as I consider, by the comparatively ineffective compression from the collodion coating in these situations.

I think, for instance, the brow would be the most favorable site for operation, all things being equal.

181 REMSEN STREET, Brooklyn.

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## THE OBLITERATION OF THE VARICOSE VESSELS IN ROSACEA BY ELECTROLYSIS.\*

BY W. A. HARDAWAY, A.M., M.D., ST. LOUIS,

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AN essential part of the treatment of rosacea is the obliteration of the hypertrophied blood-vessels which are to be seen in such profusion in the later stages of the disease.

The usual methods of operation have been either to divide the vessels longitudinally with a sharp knife, or to puncture them with a needle coated with some caustic, such as nitrate of silver, for instance. The plan that I wish to propose is very simple and satisfactory in its results; it requires as a rule but one sitting, and when properly performed leaves no scar, and causes no local reaction whatever:

A number thirteen cambric needle—a larger size should never be used—is inserted in any convenient electrode handle (Prince's is well adapted to the purpose), which latter is attached to the *negative* pole of a galvanic battery; a sponge-electrode is connected with the *positive* pole. The needle is then inserted sufficiently deep to enter the dilated vessel; so soon as this has been accomplished the patient approaches the sponge-electrode (positive) to the palm of his hand; after the electrolytic action has been properly developed,

\* Read at the third annual meeting of the American Dermatological Association, New York, August 28, 1879. For discussion thereon see page 396.

the patient releases the sponge- (positive) electrode, after which the operator withdraws the needle.

The number of elements employed will depend principally upon the susceptibility of the patient, and also upon the condition of the battery ; but where the machine is freshly charged, six or eight elements will generally suffice.

The phenomena following the introduction of the needle are quite interesting : after a few seconds the point of puncture becomes quite blanched, as does also a small area of surrounding tissue ; then the column of blood is seen, mercury-like, to run up the vessel and empty itself into the collateral branches, which apparently become distended. I presume the column of blood is forced up by the gas evolved upon the decomposition of that fluid.

If the vessel to be operated upon is a long one, and a single puncture is not sufficient for its obliteration, several must be made along its course. The needle is inserted either perpendicularly or parallel to the vessel ; when the vessel is short the latter procedure may be employed, thus destroying it at a single puncture. Under a two-inch lens, with which I always operate, there is not much difficulty in entering the needle directly into the lumen of the vessel.

When a small needle—No. 13, cambric—is used, the parts present nothing abnormal after the operation. The time required is not so long, nor is the puncture nearly so deep, as in the operation for the destruction of the hair papillæ ; therefore one does not find the same amount of reaction following this procedure as occurs in the treatment of hirsuties.\*

Whether this method is applicable in all cases, or whether the results so far obtained will be permanent in their results, I should not like positively to affirm, as the number of cases operated upon has been too few, and the time which has elapsed since the operations too limited for dogmatic assertions ; hence, I should desire this paper to be looked upon in the nature of a provisional report, to be supplemented by subsequent observation.

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## NOTES ON THE LOCAL TREATMENT OF CERTAIN DISEASES OF THE SKIN.†

BY L. DUNCAN BULKLEY, A.M., M.D.,

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**XXXIII. *Seborrhœa* (continued).**—Upon the face seborrhœa, or acne sebacea, is seen, practically, in two forms, the same as on the scalp, namely, as an oily secretion,—seborrhœa oleosa,—in which the

\* See writer's paper on the "Treatment of Hirsuties."—Transactions American Dermatological Association, 1878. ARCHIVES OF DERMATOLOGY, vol. iv. p. 337.

† These notes are intended to report for the use of the general practitioner the

skin appears continually as if oiled, or the flow may be so abundant as to stand in drops at the orifices of the glands; or, second, the secretion may appear in the form of a dry, greasy crust, formed in small masses, adhering tolerably firmly,—the seborrhœa sicca or acne sebacea cerea. Sometimes the crusts concrete into much harder masses,—acne sebacea cornea,—where they are still more firmly adherent to plugs extending into the gland ducts, and on their removal too roughly slight bleeding may be caused; this latter form appears chiefly in elder persons, and may be the starting-point of epithelioma. We will speak of the treatment of each in turn.

The oily seborrhœa will sometimes prove most seriously obstinate, for, though checked by local treatment, it may return again and again, or sometimes it seems but increased by any treatment which may be employed. In this form alcoholic washes are the most serviceable, and sometimes simply bathing the face with a little cologne-water or bay-rum will check the increased secretion. A higher degree of stimulation is obtained with the tincture of green soap as previously recommended in seborrhœa of the scalp; this frequently causes an apparently augmented secretion at first, followed by diminution. The washes previously recommended in acne simplex are also of service in this form of sebaceous derangement, and of these I may especially mention the following: R.—Potass. sulphuret., zinci sulphat,  $\frac{aa}{3}$  i; aquæ rosæ,  $\frac{3}{4}$  iv.—M., ft. lotio. R.—Sulphuris precipitat.,  $\frac{3}{4}$  i; etheris sulphurici,  $\frac{3}{4}$  iv; spts. vini rectif.,  $\frac{3}{4}$  iiiss.—M., ft. lotio. Or a bichloride of mercury wash, as follows, may be of the most service: R.—Hydrarg. chlor. corrosiv., gr. x; ammon. muriat.,  $\frac{3}{4}$  i; spts. vini rectif.,  $\frac{3}{4}$  ii; aquæ aurant. flor.,  $\frac{3}{4}$  ij.—M. In very obstinate cases I have seen the secretion checked by the local use of a solution of atropine, well soaked in, and also have used the tincture of belladonna locally with success.

The dry eruption of seborrhœa sicca requires sometimes even a more stimulating treatment than the above. The compound tincture of green soap (R.—Olei cadini, saponis viridis, spts. vini rectif.,  $\frac{aa}{3}$  i.—filter and add spts. lavandulæ,  $\frac{3}{4}$  i.—M.) may be rubbed on with a bit of flannel; this may, of course, be too stimulating in full strength, and it is well then to dilute it, either with a definite proportion of water at the time of using, or the flannel may be first dampened with water, and then the wash poured upon it. After a tolerably sharp friction with the wash at night, I have the following ointment applied well over the part, and left on until morning: R.—Bismuth. subnitrat.,  $\frac{3}{4}$  i; unguent. hydrarg. ammoniat.,  $\frac{3}{4}$  ij; unguent. aquæ rosæ,  $\frac{3}{4}$  vj.—M., ft. unguent. If this is too stimulating, a simple zinc ointment may be used. Most of the measures

local measures in common use by the writer in the treatment of diseases of the skin. It is not intended that they shall be exhaustive, nor that the measures are recommended to the exclusion of constitutional treatment. The formulæ are not claimed as original, although some of them may be. These "Notes" are continued from pages 212 and 307 of vol. ii.; pages 24, 127, and 314 of vol. iii.; pages 49, 225, and 315 of vol. iv.; and pages 45 and 251 of vol. v.

previously recommended for the other forms of sebaceous disease are also of service here.

In the hard, horny, sebaceous secretions occurring chiefly on elderly persons, and more frequently in the region of the nose, considerable care must be exercised not to unduly irritate the part, and especially not to proceed if under treatment a bleeding occurs after each removal of the crust, for even then the process of epithelial degeneration and proliferation which may result in epithelioma may have begun. These hard masses should be first softened with some very emollient ointment, and the one that I use contains a little zinc; thus, R.—*Zinci oxidi*, gr. xxx; *unguent. aquæ rosæ*, ʒi.—M. After the crusts are thoroughly loosened by this, applied several nights in succession, they are to be wiped or gently scraped off, and the surface lightly rubbed with a weak caustic potassa solution (gr. v–xv ad ʒi), and the ointment immediately reapplied. Sometimes this treatment for a few days will be all that is necessary; but more commonly the affection recurs, and the process must be repeated. In some elderly persons this is all that can be done; it will be impossible to remove the habit of the skin to form these hard, sebaceous depositions. A somewhat stronger ointment may sometimes be used with caution if it is rebellious to the preceding treatment, and the one I commonly employ is composed as follows: R.—*Hydrargyri oxidi rubri*, gr. x–xv; *unguent. aquæ rosæ*, ʒi.—M. The red oxide should be reduced to the finest possible powder, and thoroughly incorporated in the ointment.

Seborrhœa of the back or chest is a form of this derangement which is not always recognized, nor removed when its nature is known. It is most likely to be mistaken for *tinea versicolor* (*chromophytosis*), or *tinea circinata*, or for a superficial erythematous eczema, or psoriasis. It appears in the form of reddened circles or patches of greater or less extent, slightly raised, and covered with a small amount of very greasy scale, quite easily scraped off; it often itches very considerably, and there are frequently scratch-marks present. The local measures already described are quite sufficient to remove this, the best perhaps being active frictions with the compound tincture of green soap and the subsequent application of the ointment of nitrate of mercury, one part to three of rose ointment or cosmoline.

Seborrhœa of the genitals is largely overcome by persistent cleanliness, ablutions with water and tar soap; a watery solution of tannic acid, gr. x–xx ad ʒi, may be subsequently employed with advantage, applied by means of a bit of muslin dipped in it and wrapped around the glans or tucked within the vulva.

In all the varieties of sebaceous disease, however, it must be borne in mind, as stated in the beginning of this article in the last issue, that local treatment must not be too much trusted to, although the immediate effects of proper applications may be often very surprising and gratifying. There is usually some cause farther back than mere local disturbance of the skin, and unless this is

reached and rectified the result of topical treatment will be but temporary.

XXXIV. *Sudamina*.—The local treatment of sudamina is of the simplest character, the chief point to be borne in mind being to avoid all local irritation and to allow the minute vesicles to remain unruptured. For this purpose the only applications justifiable are powders, or the blandest oleaginous preparations ; of the two the former is much preferable. Frequent dusting the surface with powdered starch or rice-powder will give a cooling effect and assist in preventing friction ; lycopodium is perhaps even better than starch or rice. If the skin is hot and dry, cosmoline with a few grains (three to five) of carbolic acid to the ounce may prove grateful, or the skin may be anointed with fat bacon, as mentioned when speaking of measles and scarlatina in the last issue.

XXXV. *Sycosis*.—By sycosis is here intended the true inflammation of the hair follicles, and not the parasitic eruption falsely called sycosis parasitaria, which is but a modified ringworm or *tinea trichophytina barbæ*, under which name it will be presently treated of. True sycosis is one of the most obstinate of skin affections, and will often tax the patience and resources of the physician to the utmost, and the measures to be employed in obstinate cases can hardly be outlined in the present writing. It must also be remembered that systemic conditions are at the bottom of most cases, and that constitutional measures must be likewise employed.

In the beginning of sycosis, when there is mainly the deep-seated burning or tingling, with possibly a few scattered pustules, and some tenderness when the hairs are seized and pushed in vertically, a cooling treatment may be of service, and quite an amount of relief is obtained by the following lotion, which alone may arrest the disease : R.—*Liquor. plumbi acet. dil.*, 3*ii*; *pulv. calamin. prep.*, *zinci oxidi, aa 3*i**; *glycerini, 3*ii**; *aquæ rosæ, 3*iijss**.—M. This is to be well shaken, and the parts kept moistened with it much of the time.

When, however, the disease is well pronounced, when numerous pustules have formed, there is little or no hope of success by simply palliative or soothing treatment, and energetic stimulating measures are called for. Many writers advise epilation, but in my experience this is so exceedingly painful that few will submit to it with any degree of perseverance. When hairs are found standing loose in a well of pus, their removal facilitates the healing of that portion, for then the hair is detached from its follicle, is virtually dead, a foreign body plugging the opening and preventing the escape of pus. But a large share of the hairs in the inflamed patch of sycosis are found to be quite firmly attached, and are extracted with much pain ; and I find so much complaint of this proceeding when practised by others, and so many have seriously objected to it, that I rarely persist in requiring it, although certain writers insist that it is the only way to cure the disease.

Shaving is, however, all important, and although patients will

object to this at first, it soon becomes more and more easy, and is finally preferred by them. Care must be exercised to have the razor very sharp, and the soap thoroughly bland and unirritating. I prefer the well-known Pears' English transparent soap, which comes in packages for shaving purposes. After the shaving the skin at first may be superficially irritated, and a soothing application may be of service for a while. I have used with advantage R.—Pulv. calamin. prep., 5ss; zinci oxid., 5ss; unguent. aquæ rosæ, 5j.—M., until the acute symptoms of much burning and exudation have passed. The strength of the applications may then be increased, and the diachylon ointment of Hebra, bound on the part firmly at night, will be found very serviceable in many cases. More active stimulation is afforded by the citrine ointment, diluted from one to three times. Still greater stimulation may be necessary, when the iodide of sulphur ointment, diluted or not, or the ammoniated mercury ointment or one of calomel, may be more efficacious.

At the best many cases will be found to be exceedingly stubborn, and patient perseverance in one plan of treatment will be more likely to be successful than a changing from one method to another.

**XXXVI. Syphiloderma.**—Without attempting at all to indicate the internal measures to be employed in the syphilitic eruptions of the skin, other than to state that they should always receive constitutional treatment, I will briefly mention a few local means which have proved at times of service in their management.

In chancres, especially about the face, much more rapid removal than otherwise may be obtained by keeping them covered with the emplastrum hydrargyri of the Germans, made thus: R.—Hydrarg., 5i; terebinth. commun., 5j; ceræ flavæ, 5jss; emplast. plumbi, 5vj.—M. Powdered iodoform dusted on yields good results, but I seldom employ it, on account of the odor.

The diffuse papulo-pustular eruptions in early syphilis may be much modified by the repeated application of the calamine lotion, as recommended in sycosis, without the acetate of lead water; this serves both to cool the surface and certainly is grateful to patients, and, by the powdery coating left on, serves considerably to mask the eruption upon the exposed surfaces of the body.

In the later ulcerating, tubercular, and gummy lesions I make great use of cotton batting as a dressing for the sores, simply laid on without any other application, as powders, ointments, etc. The fibres adhere and form a scab, beneath which cicatrization goes on, under proper internal medication, much more speedily and comfortably than under other methods. It is understood that the cotton which adheres is as a rule left on, and not torn off; the outer portions, or those much saturated with pus, may be removed from time to time, but in the main the raw surface is not to be exposed daily and washed, as is the common practice, but left to heal under a scab. Those who have never tried this method will be surprised at the rapidity with which syphilitic sores, which have long remained open, will heal when thus managed; in some instances, of course, other

applications are required, and a powder of equal parts of finely pulverized iodoform and charcoal may assist very greatly to check suppuration and overcome the foetid odor of some syphilitic lesions.

XXXVII. *Telangiectasis*.—Under this term is understood *acquired* dilatation or new formation of blood-vessels of the skin, as distinguished from nævus, as ordinarily understood, and which has already been under our consideration in a previous issue. Telangiectatic conditions are seen in acne rosacea, also after ulcerative lesions as in syphilis, and occur also spontaneously. The treatment which I commonly employ for these dilated and tortuous blood-vessels is to open them by running a sharp-pointed knife, as a cataract knife, along their length, and after laying them open tolerably freely, to thoroughly cauterize the track with a sharp point of nitrate of silver, thrusting it finally into the point of entrance of the blood-vessel into the deeper skin. This operation, which is quite painful, seldom fails to give perfect results in the portion operated upon, and generally leaves no scar, or only the faintest trace if any.

Quite lately electrolysis has been reported on favorably in this condition, and I am strongly inclined to adopt it.

XXXVIII. *Tinea*.—The local treatment of the three varieties of tinea, namely tinea trichophytina, tinea favosa, and tinea versicolor, will be spoken of separately in the above order.

Tinea trichophytina requires somewhat different treatment, as it occurs on the body (*tinea trichophytina corporis*, or *tinea circinata*, *herpes circinatus* of older writers), on the scalp (*tinea trichophytina capitis*, or *tinea tonsurans*), in the beard (*tinea trichophytina barbae*, or *sycosis parasitica*), or about the thigh and genital region (*tinea trichophytina cruris*, or *eczema marginatum*).

Tinea trichophytina corporis—ringworm of the body, extremities, or non-bearded face—seldom presents much difficulty of treatment. After a good washing once or twice a day—say, with tar soap—I have the sulphurous acid applied in full strength, well sopped upon the affected parts, and left to dry on. There may be a little stinging at first, but this soon passes off, and a few days will generally suffice to remove recent eruptions. Citrine ointment diluted three times is also very efficacious, likewise an ointment of turpeth mineral twenty or thirty grains to the ounce.

When occurring on the scalp (*tinea tonsurans*), this form of disease may prove obstinate beyond all expectation, although recent cases in healthy children in private practice will frequently yield very promptly and easily. I generally commence with the use of sulphurous acid, the parts being well soaked with it twice daily. I also give an ointment, to be well rubbed in and worn all night, composed as follows: R.—*Olei cadini*, 5*j*; *unguent. hydrarg. oxidi rubri*, 5*ii*; *unguent. aquæ rosæ*, 5*vi*.—M., *ft. unguent.*

It is always best to have all the hair cut short, in order both that the local applications may be thoroughly and effectually made to the affected portions and the immediate neighborhood, and also that each and every spot of disease may be certainly determined, and no

new points go for any length of time unrecognized. In regard to epilation, it is necessary I find in more obstinate cases, but many get well without it. Early in the disease, or when the case is first seen, it can hardly be practised on account of the brittleness of the hairs invaded by the parasite ; later, when the activity of the growth has been somewhat subdued, the hairs can be drawn out, and the deeper portions will be found to be affected. When epilation is practised, after each sitting the operator should rub well in a wash of bichloride of mercury, three to five grains to the ounce. I do not deem it safe to put this in the patient's hands for general use.

In the more obstinate cases other remedies may be needed, and I have employed very many of those recommended in the books, and have very little to say in reference to the special advantages of any. I have seen very considerable inflammation excited by the oleate of mercury without curing the disease, but have also seen it succeed.

Parasitic sycosis, falsely so called, the *tinea trichophytina barbe* of our nomenclature, requires different measures according to the duration of the disease. When recent it is very superficial, and, appearing like ringworm of the body, yields to the same local applications above described. After it has lasted any length of time, however, the fungus elements find their way into the large follicles and penetrate even to their bottom, and in order that the remedies may reach it epilation is necessary in most instances. In one obstinate case in private practice nearly forty thousand hairs were extracted from the cheeks before the disease was completely cured.

The same parasiticides are applicable here as in parasitic disease elsewhere. I have succeeded very well with the ointment of oil of cade and red oxide of mercury, mentioned under *tinea tonsurans*. It is a little difficult to use sulphurous acid well on the face on account of its irritating effect on the nose, but I have treated cases with it very satisfactorily.

The parasitic eruption occurring about the thighs and pubes, also in the axillæ (*tinea tricophyton cruris*,—the *eczema marginatum* of Hebra), I have seldom found to resist sulphurous acid ; indeed, when properly employed it may almost be called a specific. In these regions the eruption partakes much more of the character of eczema, with often a very raw, red surface, with very sharply-defined edges, and care must be exercised not to irritate the skin too greatly. It is often desirable, therefore, to employ such a remedy as the acetate of lead and calamine wash, already described, for a few days, and when the acute inflammatory phenomena have somewhat subsided to employ the sulphurous acid. This latter is to be freely bathed on the parts several times daily, of a strength as great as can be borne ; generally there is no difficulty in using it as strong as can be procured. One word more in reference to this latter matter. What is known as sulphurous acid being only a solution or suspension of the gas in water, it readily becomes weaker on exposure to the air, and I therefore order a new, unopened package to be obtained, and the patient fills an ounce-bottle from this for daily use. Exposure to air also

subjects the acid to oxidation, and sulphuric acid is developed, which, instead of being curative, proves to be very irritating.

The local treatment of tinea favosa has already been considered in a former issue under the name of favus, and need not be here repeated.

Tinea versicolor (chromophytosis, or the old pityriasis versicolor) yields also to sulphurous acid, although many cases fail to get entirely well under this as under many other treatments because of too short or too unfaithful use of the remedy. Here a daily washing, first with the common yellow bar soap, followed by good friction, is a great assistance to the cure; but the difficulty is that the patches almost if not entirely disappear to the eye before all are removed from their deeper seat in the epidermis, and relapses are very common. I always insist that the treatment shall be continued at least a week or two after the patient ceases to recognize the eruption. Chrysophanic acid ointment ( $5j$ - $3ij$  ad  $3j$ ) has been highly recommended in this as in other vegetable parasitic diseases; it certainly will cure it, but the staining is so disagreeable that patients declaim against its use. It has the advantage that it renders spots of the disease evident which would otherwise escape the eye, and thus a permanent cure is more probable. Almost any of the other parasiticides mentioned are also efficient if faithfully used.

XXXIX. *Urticaria*.—Few of the not serious skin affections give more annoyance to the patient and physician than urticaria, and frequently all manner of local applications will be tried before relief is obtained; the disease should always receive very careful attention, and hygiene and dietetic as well as constitutional treatment should be employed in addition to local measures.

I have very commonly found much relief to follow the external application of a tolerably weak solution of bicarbonate of soda ( $3ii$ - $3vi$  ad  $Oj$ ), with a little glycerine ( $3ii$ - $3j$ ); the surface to be bathed with this morning and night, and to be subsequently lightly dusted with starch or rice powder. Carbolic acid is, perhaps, the remedy I use most in dispensary practice in a watery solution ( $5j$ - $5iv$  ad  $Oj$ ), and it certainly gives much relief. The "*liquor picis alkalinus*" suggested by me some years since (R.—Picis liquidæ,  $3ii$ ; potass. causticæ,  $5j$ ; aquæ,  $3v$ . Dissolve the potash in the water and add slowly to the tar in a mortar with friction) will often give perfect relief, used as a wash, diluted with from ten to twenty or more parts of water.

Baths are often of the greatest service, and I very frequently see the best results from the alkali and starch bath previously recommended in other affections, made thus: R.—Potass. carbonat.,  $3ijj$ ; sodæ carbonat.,  $3ij$ ; boracis pulv.,  $5j$ .—M. Use one such powder for a thirty-gallon bath with from one-quarter to one-half a pound of starch; the surface may be afterwards anointed with the glycerite of starch or cosmoline, with from five to ten grains of carbolic acid in each ounce. When the itching is uncontrollable, the chloral-camphor ointment, as introduced by me some time since for pruritus,

will surely give relief; it is prepared as follows: R.—Chloral hydrat., pulv. gum. camph., &c 5j. Rub well together in a mortar until a liquid results, and add to one ounce of rose ointment.

It should never be forgotten that irritating underclothing may excite and keep up urticaria, and in severe cases silk garments should be worn next the skin, or a very thin muslin may be interposed beneath a woollen shirt or drawers. But, as stated at the beginning, urticaria is very seldom a purely local skin disease, and its causes must be sought elsewhere, and other means used than local, if certain and permanent relief is desired.

XL. *Verruca*.—Warts are often very troublesome, and refuse to disappear under acetic acid, muriate of ammonia, etc.; and I would call attention to their removal by means of the dermal curette, as has been advised in Vienna. This spoon-shaped instrument must be tolerably sharp, and by a careful sort of a cutting movement around the wart it may be removed bodily, leaving a slightly depressed surface which bleeds a little; as this heals, perfect epidermis is formed, with no scar, and the wart generally remains absent. The little operation is hardly at all painful. I have experienced it on my own person, and have removed warts from children by it without their hardly knowing that it was done.

XLI. *Xeroderma*.—The milder forms of xeroderma, where there is only a dryness of the skin without much scaling or epidermal alteration, are much benefited by properly-directed local treatment. The pathological fault is undoubtedly an insufficient or unnatural action of the glands of the skin, both sebaceous and sudoriparous, and the line of treatment should be such as to stimulate their action on the one hand and to supply the deficiency on the other. Turkish, or preferably Russian baths, taken about two a week, will sometimes be sufficient; but, to have their action the most perfect, they should be followed by an inunction, and several substances may be employed for this purpose. In younger patients, linseed oil answers exceedingly well; those who are more fastidious may use almond oil, cocoanut butter, or cosmoline, all of which may be perfumed to suit the taste. The glycerite of starch is a most excellent application for this purpose, and one of which I make much use.

Where the hot-air or steam baths cannot be obtained, or are contraindicated, the alkaline and starch baths, as previously recommended in other affections, serve a most excellent purpose; they should also be followed by the inunction. These may be taken as often as three times weekly with advantage.

NOTE.—Having considered the local treatment of most of the affections of the skin which are at all common in this country, the Editor hopes in future issues of the ARCHIVES to continue this style of serial writing for general practitioners, in the way of "Clinical Illustrations of Diseases of the Skin." In these he will give cases of the more common, as well as of the rarer cutaneous affections, with commentary upon the same, including diagnosis, prognosis, treatment, etc. The cases will be drawn from both public and private practice, and some of the matter will be that delivered in Clinical Lectures at the New York Hospital.

## SOCIETY TRANSACTIONS.

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### AMERICAN DERMATOLOGICAL ASSOCIATION.

*Third Annual Meeting, held at the Park Avenue Hotel, New York City, August 26-28, 1879.*

Present, Drs. I. E. ATKINSON of Baltimore, L. D. BULKLEY of New York, L. A. DUHRING of Philadelphia, F. P. FOSTER of New York, G. H. FOX of New York, W. A. HARDAWAY of St. Louis, C. HEITZMANN of New York, J. N. HYDE of Chicago, H. G. PIFFARD of New York, S. SHERWELL of Brooklyn, R. W. TAYLOR of New York, A. VAN HARLINGEN of Philadelphia, E. WIGGLESWORTH of Boston, and J. C. WHITE of Boston.

The President, Dr. L. A. Duhring of Philadelphia, in the chair.

#### FIRST DAY. MORNING SESSION.

The Association met at 9.30 A.M., for a business meeting, with closed doors, the regular scientific proceedings beginning at about half-past 10 o'clock, with the address of the President, his subject being

#### The rise of American dermatology.

He first alluded to the importance of facts in all science, and the necessity of relying upon accuracy of observation for any progress therein. Dermatology, he said, called for the minutest observation, the proper recording of an investigation, which could now, thanks to the methods at present employed, be pursued with much greater facility than formerly, which was another point of great importance.

Benjamin Rush had said, "Sciences are not made, but grow;" and with this as the key-note of the whole, he then proceeded to give a sketch of the rise and progress of American dermatology, which he said could claim a parentage, and that no mean one. In the broad sense in which this term is to-day employed, it was of recent birth, dating back scarcely farther than a period within the recollection of the members of the Association; but there were many earlier pioneers in this field who labored (though with many disadvantages) faithfully in their day and generation. In appreciating their noble efforts it was necessary to bear in mind the state of medical science in the period when they lived.

Dr. Duhring now gave an exhaustive *résumé* of all the earlier medical literature having a bearing on dermatology that was ever

published in this country, so far as he was able to ascertain. Among the works mentioned were the following: "A Brief Guide in the Smallpox and Measles," by Thomas Thatcher, 1677 (believed to be the first medical publication that appeared in New England, and probably in America). Small works by Benjamin Colman, Zabdiel Boylston (who introduced the practice of inoculation into this country), Nathaniel Williams, William Douglas, and Laughlin Maclean. A book on cancer, by Cadwalader Colder, a man of great learning and high attainments, and also author of a volume on the climate and diseases of New York. "An Essay on the Causes of the Different Colors of People in Different Climates," by John Mitchell, of Virginia. (This work proved its author a deep thinker as well as an ardent dermatologist. In it he showed that different colors were caused by climate and circumstances, and argued from this the common origin of man.) "An Historical Account of the Climate and Diseases of the United States of America," by Dr. Currie, containing a description of the eruption produced by "the rhus vernix, or poison sumac, and by a small creeping vine resembling the ivy, called rhus radicans, or poison ivy." "An Essay on the Causes of the Variety of Complexion and Figure in the Human Species," by Samuel Stanhope Smith, a noted president of the College of New Jersey, 1787. (An elaborate article which attracted considerable attention in Europe, and of which a second edition was published in 1810.) Works on "Smallpox," by Ninian Magruder; "Scarlet Fever," by Matthias Williamson; "Gangrene and Mortification," by Francis Huger; and the "Effects of Contagion on the Human Body," by Lewis Condict. "An Experimental Dissertation on the Rhus Vernix, Rhus Radicans, and Rhus Glabrum," by Thomas Honfield. "A Dissertation on Perspiration," by James Agnew, of Princeton, New Jersey (Philadelphia, 1800). "A Thesis on Absorption," by John Baptist Clement Rousseau (1800), in which the author discusses some of the effects of mercurial frictions. "On the Warm Bath," by Dr. Lochette, of Virginia (1800). "Lues Venerea; the Modus Operandi of Mercury in Curing it. Gonorrhœa," etc., by James Tongue, of Maryland (1800). (In this the author undertook to prove that syphilis was not introduced into Europe from America, and that syphilis and gonorrhœa were two distinct forms of disease.) "Cutaneous Absorption," by H. P. Dangerfield, of Virginia.

Vaccination was the all-absorbing topic in America, as in Europe, at the close of the eighteenth century. In 1797, Jenner's discovery was made public, and early in 1798 the news came to America. A copy of Jenner's famous "Inquiry" was quickly forwarded to Dr. Waterhouse, of Cambridge, who published a paper on the cow-pox virus in the *Columbian Gazette*, and soon afterwards vaccinated seven of his own children with material from Jenner's stock. In 1800 was issued his well-known brochure, "A Prospect of Exterminating the Smallpox." Then followed numerous pamphlets on the subject of vaccination; among which were cited "The Jen-

nerian Discovery," by C. R. Nilsen, and "Letters on the Kine-pox," by Oliver and Currie.

Towards the close of the first decade of the nineteenth century were written two Boylston prize essays by Dr. George S. Shattuck, one of which was on "The Structure and Physiology of the Skin, with a view to the Diagnostics and Cure of Diseases usually denominated Cutaneous" (a work denoting considerable originality and depth of thought). But the profession in America were simply not qualified to deal with the subject of diseases of the skin at this date.

In 1836 the Broome Street Infirmary for Diseases of the Skin was established in New York, with Drs. H. D. Bulkley and John Watson as physicians in charge; and the following year a course of lectures on diseases of the skin was given by Dr. Bulkley, who had fitted himself in Europe to teach this branch. This was the first course ever delivered on the subject in this country, and in the ten years succeeding eight other courses were given by Dr. Bulkley, some of them at the Broome Street School of Medicine, some at the New York Dispensary, and some at the College of Physicians and Surgeons.

As was to be expected, American dermatology for a time was thoroughly tinctured with French views and methods, since in England and Germany opportunities for the study of cutaneous affections were almost entirely wanting.

In 1838, a department for diseases of the skin was opened at the Northern Dispensary, in New York, and Dr. A. N. Gunn received the first appointment in it. The profession was now fully alive to the importance of the subject, and a number of original essays on dermatological topics, besides many reprints of many European articles, appeared during the next few years. In 1837 a reprint of Plumb's "Practical Treatise on Diseases of the Skin" was issued, and in the following year one of Greene's "Practical Compendium of Skin Diseases." Then followed two more editions of Hunter's treatise on the venereal disease, with notes by different writers, and also American editions of the works of Ricord, Dendy, Erasmus Wilson, and others.

The year 1845 witnessed the first American book on dermatology, by N. Worcester, M.D., Professor of Physical Diagnosis and General Pathology in the Medical School of Cleveland, and a few years later appeared the classic work of Prof. George B. Wood, which contains excellent chapters on diseases of the skin. About the year 1830, the University of Pennsylvania came into the possession of a large and fine collection of models of skin disease, which had been procured in Europe by Prof. Wood, and constituted the first treasure of the kind ever brought to America. Foreign works by such masters as Hunter, Ricord, Vidal, Jahr, Wilson, and Neligan were continually being added to our libraries, and at length appeared the original dissertation (a Boylston prize essay), by Silas Durkee, of Boston, on the constitutional treatment of syphilis. Various special

institutions and departments for the treatment of diseases of the skin were now opened in the dispensaries in all the larger cities, and men who had studied the subject under the best teachers in Europe were beginning to return to America to practise and give instruction. In 1853 the Demilt Dispensary, New York, and the Howard Hospital, Philadelphia, each opened departments for cutaneous disease, and in 1861 the first course of lectures in Dermatology in Harvard University was given by Dr. J. C. White.

Shortly after the close of the war clinical lectureships on dermatology were established in the principal medical schools of the country. The first incumbent of this chair in the Jefferson Medical College, Philadelphia, was Dr. F. F. Maury, lately deceased; and, in alluding to this fact, Dr. Duhring paused to pay an elegant tribute to his brilliant talents and many noble qualities.

Towards the close of the decade of 1860 to 1870 the translation of Cullerier's treatise on venereal diseases, by Dr. F. J. Bumstead, and Dr. Piffard's translation of Hardy's brochure on "The Dartrous Diathesis; or, Eczema and its Allied Affections," appeared. In 1868, Dr. Piffard read a paper on the state of dermatology before the New York Medical Journal Association, in which he urged the necessity for a definite classification and nomenclature. Nomenclature, said Dr. Duhring, was undoubtedly of more importance than classification, and he looked forward to a uniform nomenclature at no distant date. The labors of the American Dermatological Association had already accomplished no little towards such a desirable result.

At this period many Americans were studying in Europe, who took up the subject of dermatology with special fervor under the stimulus that was urging all on to original investigation, and not a few of whose names are now as well known abroad as in the United States. In 1869 the New York Dermatological Society, which has exerted a marked influence on the study of the science, was organized, with Dr. H. D. Bulkley as its first president.

With 1870 a new and promising era commenced, and an important step forward was the establishment of the "American Journal of Syphilography and Dermatology," so ably edited by Dr. M. H. Henry. During these years American Dermatology was born, and commenced to grow and thrive. The influence of Hebra began to be felt, and, many of his pupils now returning to this country, old and erroneous opinions previously entertained here were exposed and overthrown. From nothing the solid organization of to-day had arisen, and American Dermatology was now recognized everywhere. The grand result of the honest labor put forth, which had been accumulating for the last ten years, was so obvious and cheering that it sufficed to say that we undoubtedly had at present a science of dermatology which the profession, and particularly the members of this Association, might regard with sentiments of just pride. In conclusion, Dr. Duhring expressed his cordial thanks to the various members for their services in securing information

for this address, which without their assistance would scarcely have been possible.

The first paper read was by DR. ATKINSON, on

### A case of incomplete vitiligo.\*

DR. SHERWELL remarked that he had a case which appeared somewhat similar to that reported, but he, as well as Dr. Fox, who had seen it, believed it to be one of macular leprosy, the surface around the white patches being distinctly raised and also slightly scaly. The case was improving under treatment. He would be glad to exhibit it to the Association if opportunity were offered.†

DR. WHITE thought it a matter of importance that the restoration of color spoken of by Dr. Atkinson should have occurred under the care of a careful observer, and he believed that it was the first instance of the kind recorded.

DR. TAYLOR stated that he was acquainted with a Dr. Burdick, of Vermont, who had leucoderma every summer, which faded away as the cold weather came on, and by winter had entirely disappeared.

DR. HARDAWAY called attention to a paper by Dr. Yandell reporting a number of cases of vitiligo which seemed to show that in the negro it is not always a permanent affair.

DR. BULKLEY referred to a case of leucoderma in a very dark-complexioned Cuban, in whom the hairs upon the white patches had maintained their jet-black color. In this case there had been a return of normal pigmentation in some of the spots under his own observation.

DR. FOX remarked that Dr. Atkinson's case of incomplete vitiligo explained many of the cases in which the disease has disappeared, and also the variable condition of the hairs. In the *complete* forms he was inclined to believe that the hairs were invariably white, and that no return of pigment ever took place. It was a difficult matter, however, to say whether there was or not a complete absence of pigment. He had had the opportunity of seeing a number of cases of leucoderma. One of them was of unusual interest, inasmuch as there was an increase of pigment before the latter disappeared; in other words, there was combined melanoderma and vitiligo. He thought this was probably the general rule. In regard to the absence of color beneath the prepuce in negroes, alluded to in the paper, he had sometimes observed in those who were not the subjects of leucoderma that the anterior portion of the glans which was exposed to the air was pigmented like the rest of the skin, while the posterior portion, being covered, presented the same appearance as in whites.

\* Published in full in this issue of ARCHIVES, page 329.

† The case was shown to the Association at a clinical session held at the New York Hospital on the last afternoon of the meeting, and was pretty certainly determined to be one of true leprosy. The mother of the patient, who was a boy of about seven years, was a native of one of the West Indian Islands.

DR. BULKLEY called attention to a colored plate in the atlas of Mr. Erasmus Wilson, in which melanoderma was combined with vitiligo, and remarked that there were a number of such cases on record.

DR. HYDE then read a paper on

**A contribution to the study of the bullous eruption induced by the ingestion of the iodide of potassium.\***

DR. WHITE inquired if the writer, in excluding the sebaceous glands, believed that the sweat glands had also no part in the matter?

DR. HYDE would not exclude them, but had reference to the sebaceous glands alone, and rather believed that the sweat glands might share in the process.

DR. WHITE remarked that some recent investigations seemed to show that iodine passes out through the sweat glands much more freely than had been supposed.

DR. TAYLOR, in support of this remark, mentioned a case of tinea versicolor in which the patches of disease were tinged bluish, and the explanation he had given was that the iodine (from the iodide of potassium which the patient was taking), being eliminated in the sweat, combined with the starch of the shirt, and thus produced the blue stain.

DR. WIGGLESWORTH inquired if any one present had seen a bullous eruption produced by the administration of bromide of potassium. Six years ago he saw a lady who had been taking bromide of potassium under the direction of Dr. Brown-Séquard for epilepsy. She had been troubled with eczema, and after a time bullæ appeared upon the body, which were somewhat acuminate, and varied in size from that of a split pea to that of the end of the finger. In some cases the bullæ ruptured, leaving sometimes a simple fringe of torn epidermis and sometimes an ulcerated surface. In many of the bullæ the color was so dark that the presence of blood was indicated.

There was not so much itching as in uncomplicated eczema, but the lesion was so severe that a doubtful diagnosis was given. The affection was treated as a simple eczema for a while, but this almost ulcerated condition with thick crusting continuing, Dr. Wigglesworth advised that the bromide should be discontinued. The patient was unwilling to do this at first, but afterwards consented, and the improvement was very rapid. The patient had taken no bromide since, and had had no return of the eruption, although she had had one or two light epileptic seizures. He had never met with a similar case.

DR. VAN HARLINGEN remarked that arsenic had been employed by some for the purpose of preventing skin lesions caused by the iodide and bromide of potassium, and asked for the experience of those present in regard to the matter.

\* Published in full in this issue of ARCHIVES, page 333.

DR. WHITE mentioned that an observer of great experience in the administration of bromide of potassium—Dr. James Putnam, of Boston—had tried it extensively and believed that it had a marked effect.

DR. TAYLOR said that he had tried arsenic, and had come to the conclusion that it had more effect in controlling the skin trouble caused by the iodide than that occasioned by the bromide of potassium. In two cases of syphilitic epilepsy where an eruption was caused by the bromide, arsenic had no power whatever to control this lesion. In answer to a question from Dr. Wigglesworth he stated that he did not consider that the therapeutic efficacy of the iodide was in the least impaired by the co-administration of the arsenic.

DR. DUHRING related a case in which the patient, who was referred to him by Dr. Seguin, of New York, was suffering from a tuberculo-pustular eruption, occasioned by the bromide of potassium. As he had been in the habit of using arsenic for such eruptions, he ordered two or three minims of arsenical solution to be given in conjunction with the bromide, which Dr. Seguin thought it was not possible to discontinue. The result was that the patient improved almost immediately. Her complexion was thus kept in good condition for two or three months, when her menstruation became disordered and the arsenic was omitted. The eruption from the bromide then reappeared; the arsenic was then resumed with the same result as before.

This case seemed to show conclusively the good effect of the arsenic. The administration of the drug for this purpose was first proposed by Dr. Echeverria, of New York, ten or fifteen years ago; Dr. Weir Mitchell, of Philadelphia, was also in the habit of using it, and obtained excellent results therefrom.

On motion of Dr. Bulkley the thanks of the Association were tendered to the president for his valuable address, the preparation of which must have involved much labor and research.

On motion of Dr. Wigglesworth it was voted that Thursday afternoon should be devoted to the inspection of such cases as the members of the Association might present; and on motion of Dr. Hyde a committee of two were appointed by the chair to select a suitable place for this purpose. Drs. Bulkley and Taylor were thus appointed.

#### FIRST DAY. AFTERNOON SESSION.

DR. BULKLEY read the details of

#### Two cases of chancre of the lip, probably acquired through cigars.\*

DR. HEITZMANN stated that the second of Dr. Bulkley's cases was familiar to him, as he had seen the patient several times, and

\* Published in full in this issue of ARCHIVES, page 343.

that there were a number of points of interest about it. When he first saw the physician the sore on the lip had a dry crust upon it, and there was a mass of glands beneath the jaw as large as a goose-egg. He could not give a positive diagnosis at once, but when the crust had been removed by emollients he had no doubt whatever that the lesion was a chancroid. On the penis also there was now apparently a chancroid, which seemed to have been caused by the fingers handling the part after having been in contact with the lip. Both these lesions presented the typical characteristics of chancroid, and yet when next seen, a week or two afterwards, all the symptoms of secondary syphilis had developed. This case, therefore, seemed to show that the duality doctrine was not tenable, a conclusion which had long ago been reached by Hebra and other high authorities. Ricord claimed that chancroid never occurred on the lip.

As an instance of communication by other means than by venereal contact, and to show that what appears to be a Hunterian chancre may not be followed by constitutional symptoms, Dr. Heitzmann related the case of a barber who had what was apparently an undoubted hard chancre in the mouth, which, as far as could be ascertained, he had contracted from dental instruments. He had told him that an eruption would follow, and yet more than ten years had now elapsed without the development of any constitutional symptoms.

DR. BULKLEY attributed the lack of induration in the chancre on his second patient, to which Dr. Heitzmann had alluded, to the fact that mercury had been taken for some little time. In his experience chancres on the lip did not present the distinct parchment hardness exhibited by those on the penis; the induration was more diffuse.

DR. WHITE inquired what real evidence there was that the chancres in these cases originated from cigars?

DR. BULKLEY replied that the unusual intelligence of the patients had aided in excluding other means of contagion, and there was a strong presumption in favor of this origin, as stated in the paper. In all other cases of chancre of the lip there had been some discoverable cause.

DR. ATKINSON related three cases which he thought should make us very cautious in arriving at a diagnosis. The first was that of a young man with a sore of the size of a twenty-five-cent piece on the cheek. It was flat and distinctly glazed, and on pressure a cartilaginous hardness was felt. The hair had fallen out from the part, and there was a collection of enlarged glands near the angle of the jaw. The diagnosis was chancre of the cheek, and a few days afterwards secondary symptoms appeared.

About the same time Dr. Atkinson saw another young man, who had hurt his hand, and afterwards exposed it to cold, and used it much. The irritation thus caused produced a very peculiar sore. It was red, elevated, with a scanty discharge, and of a cartilaginous hardness, while the epitrochlear gland was enlarged, and had a streak

of lymphangitis running up to it. The patient being much run down in health, he was given iron and quinine. In a few days he was seen again, when it was found that the whole surface was in a state of phlegmonous erysipelas; he then got entirely well.

The third case was that of a washerwoman, who had a sore on her thumb presenting the same general aspects as in the preceding case, though there was no glandular complication. No specific treatment was adopted, and the patient recovered. Dr. Atkinson said that he mentioned these cases simply because of the appearances which the sore in each instance presented. He believed, therefore, that those who make a diagnosis of chancre and chancroid from the physical appearances alone have a very forlorn hope.

DR. TAYLOR did not think that Dr. Bulkley had traced the chancres to cigars very satisfactorily. He had seen cases of non-venereal communication in which he said the origin was more clear, and mentioned that of a sailor who had contracted a chancre of the mouth from a cup out of which he drank in common with a comrade; also that of a young man who was infected by means of a towel used by a room-mate. He had had considerable experience with chancres of the lip, and, as a rule, had found them very hard, the induration sometimes being of an ivory-like character. If they were situated near the vermillion border, particularly, they were apt to have all the characteristics of typical Hunterian chancre. In children, however, they were not so hard. Dr. Taylor said that he was startled by Dr. Heitzmann's remarks in regard to dualism. He believed that as sure as there was a sun in heaven there were two forms of disease. The so-called dualists had themselves rejected this name of dualism, but at the same time they were more firmly convinced than ever of the correctness of their position. The speaker then went on to cite some of the best authorities and the result of their investigations on the subject. He thought that Dr. Heitzmann's view that because the patient had a chancroid on the penis, the lesion on the lip must be of the same character, was untenable. If pus from a chancre were applied to any part and there was irritation enough, it would produce only a sore like a chancroid.

DR. HYDE remarked that Dr. Taylor had omitted to mention that some of the best descriptions of chancroids of the face had been given by Prof. Profeta, of Florence. He could endorse fully the statements of Dr. Taylor, and also what Dr. Atkinson had said about the physical characteristics of venereal sores. Whatever theories there might be about dualism and unicism, the fact remained that there are two forms of sores, although not two forms of syphilis. In conclusion, he said that he had long since given up the idea of attempting to trace the mode and source of communication in extra-genital chancres. In most of these cases we had absolutely no proof.

DR. WIGGLESWORTH related a case of extra-genital infection in which the patient, as in these cases of Dr. Bulkley's, was a physician. The first lesion was upon the tonsil, and resembled follicular

tonsillitis. It became necessary to excise the tonsil, after which sloughing followed. The physician had attended a woman in confinement, and the child (which was syphilitic) being partially asphyxiated when born, he had placed his own mouth to its lips.

DR. BULKLEY, in bringing the discussion to a close, said that syphilis was no longer a venereal disease exclusively, and that he had related these cases in order to enable us the better to protect ourselves and our patients from it. He did not of course claim that the method of contagion was absolutely demonstrated in these cases, and the uncertainty was expressed in the "*probably*" of the title of the paper; we could never be perfectly positive of such matters. He desired simply to call attention to a means of communication of syphilis which might be very common, from what was known in regard to the habits of cigar-manufacturers as illustrated by the cases alluded to. In reply to Dr. Taylor he would say, that while he had seen chancres of the lip presenting a considerable hardness, it was of a more diffuse kind, and not the thin, parchment-like hardness seen in the Hunterian chancre on the penis.

DR. FOX then read a paper on

#### The treatment of eczema and ulcers of the leg by an elastic tubular bandage.

Before proceeding to read it, DR. FOX passed around photographs of cases referred to in the discussion of DR. ATKINSON'S paper, also some illustrating his own paper, likewise specimens of the tubular rubber bandage of which he was to speak.

Impermeable dressings combined with elastic pressure, he said, had been found to be most advantageous in the affections named. MARTIN'S bandage was too well known and highly appreciated to require description or comment. The elastic tubular bandage, which in his practice he had found preferable in many respects, was to be applied by drawing it on the part, stretching it as required; he showed one upon his own leg, which he had worn twenty-four hours with perfect comfort. The diameter of the rubber tube is to be chosen with reference to the size of the part to be covered.

As a rule, the lighter the bandage (provided its weight was compatible with strength and durability) the better, and the cheaper would it be to the patient. Where forcible compression was required, as in some severe cases, a heavy bandage was necessary.

In applying the rubber tube, whether heavy or light, it was best to oil the parts first, thus the entire foot and leg, if it is to be applied there. In eczema ichorosum of the leg, a heavy bandage might be applied for one or two days at first to macerate the epidermis and force the serum to escape. So in cases of chronic scaly eczema, with great thickening and induration, nothing would promote absorption as readily as the firm pressure of such a heavy bandage. In ulcers of the leg, also, it could be applied with an effect similar to that produced by the ordinary elastic bandage; and

in ulcers about the ankle which showed a tendency to heal it was often not necessary to apply it over the ulcer itself, but if applied merely to the calf above, it was sufficient; the explanation being that it removed the blood-pressure above. The tubular bandage was furthermore useful as a prophylactic against ulcers when there were varicose veins.

The advantages of a tubular over a long, narrow rubber bandage, as usually employed, seemed to be:

1. Its lightness. The thin, tubular bandage was scarcely felt by the patient wearing it, and it was far less likely to irritate the skin than the other form. It appeared also, he thought, to check the action of the perspiratory glands rather than to excite it.

2. The equable pressure which it exerts.

3. The saving of time and trouble. In most cases it was not necessary to remove the bandage in order to cleanse or dress the affected part; it could easily be rolled up or down.

4. Its cheapness, on account of the small amount of rubber used in its construction.

DR. BULKLEY suggested that it might be used to form an impermeable dressing in eczema of the hand, the end being gathered together by a string around it, thus making a bag into which the hand could be thrust. In referring to Martin's bandage, he said that we must not forget that Dr. Martin, in his original paper, recommended only a special kind of rubber, in the vulcanization of which only the smallest possible amount of sulphur was used, on account of the irritation of the skin which might otherwise be caused. Some skins did not bear this treatment well.

DR. HEITZMANN then gave the results of some

#### Microscopical studies on inflammation of the skin.\*

The matter was given extemporaneously, and was illustrated by pencil-drawings, executed during its delivery, to demonstrate his views of the subject.

DR. SHERWELL asked the speaker how he could distinguish the poorest pus-corpuscle, derived from a tolerably healthy individual (as in the case of long-confined pus), from those taken from a patient with marked cachexia.

DR. HEITZMANN replied that pus which had been in the body for some time always presented peculiar characteristics. Ordinarily it underwent fatty degeneration, but sometimes cheesy transformation took place. Again, if crystals of hematoidine were found in the pus, it showed that it came from an old abscess.

The committee appointed in the morning (consisting of Drs. Bulkley and Taylor) to obtain a suitable place for the clinical meeting of the Association on Thursday afternoon, reported that they had secured the large amphitheatre of the New York Hospital, and

\* Abstract published in full in this issue of ARCHIVES, page 347.

on motion it was decided to meet there, at half-past two o'clock, to observe such cases as the gentlemen might be able to secure.

A letter from Dr. Fanueil D. Weisse was then read by the Secretary, regretting inability to be present, and offering certain suggestions, as follow:

"It has occurred to me that it would be well for the members of the Association to assign to themselves a year's work in special directions, so that at the end of the year they may be able to contribute their collective clinical experience. I would move that the Association (by its President) appoint working committees of one or more on special (clinical) subjects, to report in writing at the next annual meeting, each report to constitute a paper to be read at said meeting, and each member will be expected to contribute his year's experience on the subject.

"As samples of the work which could be done in this way, I would suggest the following subjects:

"The therapeutics of acne.

"The therapeutics of infantile eczema.

"The Association, however, will of course select such subjects as it may deem most appropriate, but it seems to me that the work should be of a clinical nature."

The communication was accepted and placed on file, but no direct action in relation to the suggestions made was taken.

#### SECOND DAY. MORNING SESSION.

The report of the Treasurer was received and accepted on the recommendation of the Auditing Committee.

The Nominating Committee reported the following officers for the ensuing year, who were then elected:

*President*, DR. L. A. DUHRING, of Philadelphia; *Vice-Presidents*, DRs. EDW. WIGGLESWORTH, of Boston, and W. A. HARDAWAY, of St. Louis; *Secretary*, DR. A. VAN HARLINGEN, of Philadelphia; *Treasurer*, DR. I. E. ATKINSON, of Baltimore.

The following gentlemen were elected active members: DR. A. R. ROBINSON, of New York, and DR. J. E. GRAHAM, of Toronto, Canada.

DR. PIFFARD read the first paper, entitled

#### Viola tricolor.

The first part of the paper was devoted to an historical sketch of the various references to the plant (the wild pansy) by old writers. It was related that the fresh herb in small doses slightly increased the perspiration and urine, and gave to the latter the odor of cats' urine. In larger doses he found it emetic. It was supposed to contain an active principle, violin, which was probably identical with that of ipecac, emetin. Dr. Piffard then quoted from a brief article on the drug written by himself for the American edition of Phillips's *Materia Medica and Therapeutics*.

*Active ingredients.*—Little known ; Boullay failed to find violin in the plant (Gubler).

*Physiological action.*—A strong infusion has an exceedingly mild action, sometimes proving slightly laxative, at other times diuretic ; as a rule giving rise to very little disturbance.

*Therapeutic action.*—Viola tricolor has long been a favorite in France in the treatment of eczema capitis et faciei, and the writer had employed it for many years with great satisfaction in chronic cases of this affection. The watery preparations had appeared to answer better than the alcoholic, and he usually gave an infusion, combined with purgative doses of senna, for the first few days. Afterwards the viola is continued alone. For children one to two drachms may be macerated in half a pint of cold water for twelve hours, then boiled, and milk and sugar added ; this amount to be taken daily. Viola tricolor is not found wild in this country, except slightly, in a small and insignificant form, and the cultivated plant is not to be relied upon. The imported herb should alone be employed, and care be taken to procure a good quality ; most of that in the market is of inferior quality. The writer exhibited specimens, which showed great differences ; he also showed a fluid extract, which he had had made from some recently imported.

He considered it to be eminently useful in eczema about the upper part of the body, and especially when confined to the head ; it aggravated that occurring on the lower part of the body. Children should take five to ten minimis of the fluid extract, and adults a drachm. When the drug was used no external applications were required, or at least only vaseline or zinc ointment.

DR. TAYLOR asked if it was as beneficial in adults as in children. Dr. Piffard replied that it was chiefly used in children ; it was originally employed in *crusta lactea*, which scarcely occurred in adults. To an inquiry of Dr. Hardaway as to whether the homœopathists did not make a mother tincture of it, Dr. Piffard said that they did, but that he did not like it, as he preferred the watery to the alcoholic preparations.

DR. WIGGLESWORTH inquired if the drug tended to cause congestion of the skin, as the writer had stated that it at first aggravated eczema. Dr. Piffard replied that he could not find any evidence that it did, although it was supposed by the homœopathists to have this effect.

DR. WHITE asked if any good effect was attributed to the senna which was given with it. Dr. Piffard stated that he was in the habit of using a purgative in eczema, and often resorted to the senna, in combination with the viola, for this purpose.

DR. HEITZMANN remarked that the great merit of Hebra was that he showed that skin diseases, like other affections, took their course independently of the interference of the physician. All sorts of drugs were given internally at that time, and Hebra found that the affections went on just the same whether they were taken or not. Hence he was frequently in the habit of ordering some placebo,

merely for its moral effect upon the patient. All that internal medication was now given up. *Viola tricolor* was once thought to be a very powerful remedy in skin diseases, but the speaker did not believe that any dermatologist had any confidence in it to-day. Personally he did not consider that it had the slightest effect, although no injury would result from its use, as it was perfectly harmless.

DR. FOX stated that he had the greatest possible respect for Hebra's opinion; but he had treated eczema with both local and internal measures, and while he had faith in the local, he had known more cases cured by internal treatment alone. He had found great benefit to be derived in eczema from the administration of a mild purgative for a few days. In regard to the *viola tricolor* he remembered hearing Hebra speak contemptuously of it, but personally he had seen good results follow its use, especially in certain cases of erythematous eczema, where the most approved Vienna (local) treatment had failed. He was convinced that Hebra went to extremes in utterly condemning the use of purgatives in the treatment of eczema.

DR. WIGGLESWORTH thought Dr. Fox somewhat in error in the last statement that he made. He believed that Hebra taught that purgatives were of great value temporarily in cases with marked congestion, although he did not regard them of any permanent value.

DR. FOX replied that he thought that there could be no doubt that in his writings Hebra strongly condemned the use of purgatives, although in his lectures he had sometimes expressed the opinion stated by Dr. Wigglesworth. He wished to allude to one other point in addition to what he had said,—namely, that he had not seen eczema, other than on the head, relieved by purgatives.

DR. HARDAWAY said that with Hebra he believed that any specific for eczema was out of the question, and personally he had always failed in the use of internal remedies. He trusted exclusively to local treatment, as a rule, and the only internal remedy which he thought of the slightest service (and it was always difficult to decide about such matters) was ergot.

DR. SHERWELL agreed with Dr. Fox as to the utility of a certain amount of purgation, and said that he always commenced his treatment of scald-head in this way.

DR. PIFFARD did not regard eczema as purely a local affection; behind it there was as much constitutional disease as in syphilitic affections. Dr. Heitzmann had said that modern dermatologists did not believe in *viola tricolor*, but the latest authorities, such as Hardy, Bazin, and other writers of the highest repute who advocate it very strongly, had not been mentioned, for the reason that it was supposed that all were familiar with their views. He thought that some cases of eczema would get well under local treatment, some under internal, and some under both combined, but he was convinced that in general internal treatment was of more service than local.

DR. VAN HARLINGEN read the second paper, upon

**A case of hitherto undescribed tuberculo-pustular disease  
of the skin.\***

The patient, a woman 39 years of age, had had some eruption since early life, it being always better in autumn than at any other part of the year. On careful examination there appeared to be two forms of disease present: the one an irregular, ill-defined eczema, principally affecting the head, arms, and back; the lesions of the other, which were single, distinct, and solitary, were situated to a great extent upon the legs and ankles. These were tubercles, oval in shape, slightly elevated, and often as large as the thumb-nail. Fifty were counted on the left and thirty on the right leg. Some of them contained a small amount of pus in the centre, and among these tubercles there were a few deep scars, which were said to have resulted from the disease in childhood, when there was ulceration.

When the tubercles began to form the first symptom was local itching, which was soon followed by an urticarial elevation, and in about eighteen hours the lesion was fully developed,—being from one to one and a half centimetres in diameter, of a pink color, and looking like a large moist drop. Later, exudation took place, followed by the conversion of the fluid into pus, and the occurrence of a depression in the centre of the tubercle. The whole nodule at length became pigmented, and sank to the level of the general surface, having a white spot in the centre. One of them might last for years altogether, and sometimes there was a return of the lesion in the same spot.

The itching was not excessive, and there were no marked subjective symptoms. The patient was under observation for about three months, during which time iodide of potassium and bichloride of mercury were tried with no benefit. In the last month Dr. Bulkley's *liquor picis alkalinus*, used locally, seemed productive of some improvement.

It was at first thought that the disease was a scrofuloderm, but a microscopic examination of specimens from the lesions showed it to be purely of an inflammatory nature. Nothing like a genuine cell-infiltration, such as is seen in scrofulodermata, could be found. At the conclusion of the paper, Dr. Van Harlingen presented sections under the microscope for inspection.

DR. HEITZMANN remarked that Dr. Van Harlingen had kindly handed him some specimens for examination previously. Two of them, which were from a recent lesion, were mounted in Canada balsam, and, therefore, he was not able to tell much about them, but as far as he could judge he was in no doubt but that the affection was of an inflammatory nature. The third specimen, from an older lesion, denoted a hyperplastic condition of the skin. The main change was in the capillaries of the papillæ, which were actually

\* To appear in full in a future issue of the ARCHIVES.—ED.

transformed into firm strings. The whole surrounding tissue was profusely marked with pigmentation, as often seen in chronic disease. The fact that the capillaries were converted into connective tissue showed how the pigmentation took place: the blood-corpuscles not being able to get back into the general circulation, because disorganized and their coloring matter diffused. From the history that had been given he thought it ought not to be made a special form of disease, but should rather be regarded as merely a case of eczema which had been aggravated by scratching, with chronic urticaria or erythema.

DR. VAN HARLINGEN did not think it possible that the lesions could have resulted in this way. The history of the evolution in a few hours, as described in the paper, argued strongly against such an hypothesis.

DR. DUHRING stated that he had had the opportunity of seeing the case, and at a glance had recognized it as one which was different from any that he had ever met with before. While under his observation there was no special change in the lesions, but he was informed that new ones developed from time to time, and that they sometimes recurred in the same site. From the appearance alone it looked most like a case of erythema multiforme; but the history of course precluded any such diagnosis. Moreover, the fluid exudation, which in the course of a few days became pustular, and if undisturbed always underwent gradual absorption, leaving finally a ring of very remarkable granular pigmentation, showed it to be an extraordinary affection. Viewing the disease clinically, he was unable to classify it under any head at present recognized. What was apparently an eczematous feature in the case he felt inclined to regard as part of the same general process; the principal difference was that the papular lesions were smaller on the upper part of the body. Hence, he should be very loath to accept the explanation of Dr. Heitzmann, that the whole case was merely one of aggravated eczema.

DR. VAN HARLINGEN said that what struck him most was the rapidity with which the evolution of the lesions took place. Within thirty-six hours from its commencement the pus formation was found in the centre.

DR. ATKINSON thought that he had seen two or three cases which might perhaps seem a connecting link between the disease in question and erythema multiforme. In them the lesions were depressed in the centre and presented exactly the appearance of containing fluid, yet when they were incised this was found not to be the case. They rapidly assumed the form of tinea circinata, and extended even to the mucous membrane. There was intense itching, and the process would last from four or five days to three weeks; while in one case the lesions frequently returned. The disease was markedly influenced by arsenic, and this was also true of a case of the same kind described by Mr. Hutchinson, a plate representing which he remembered in the *Atlas of the New Sydenham Society*. There

was no cicatrization in his own case and no interstitial absorption, and hence the process never went on to the extent that it did in Dr. Van Harlingen's case.

DR. SHERWELL next read a paper upon

### Tattooing of nævi.\*

He said that this one was merely supplementary to a previous paper upon the same subject which he had read before the New York Dermatological Society, February 13, 1877, and which had appeared in the ARCHIVES OF DERMATOLOGY, vol. iii. p. 214. The method employed was substantially the same as before described, which consisted in pricking the surface freely with a bundle of needles dipped in carbolic or chromic acid of a strength of from twenty-five to forty per cent. The surface was then dried and sponged off with alcohol and a thick layer of collodion applied. A patient was shown upon whom this had been performed several times, and a history of her case was given. She had had a large flat vascular nævus, or port-wine mark, involving all of the chin and the vermillion border of the lip, which had, however, almost entirely disappeared under this treatment. One spot which had existed on the cheek had been cured by one operation. The whole surface had been tattooed twice since September, 1877, and it was proposed to remove the remaining discoloration by one more operation in the autumn.

While this method of treatment was neither painless nor instantaneous, and although it left some scar (contrary to what he had formerly believed), Dr. Sherwell thought that it had advantages over all others.

DR. HEITZMANN said that he had not had an opportunity of reading Dr. Sherwell's former paper, but he thought that the title was a misnomer, since tattooing was in reality the introduction of a coloring matter into the tissues. The method described by Dr. Sherwell was an old one. For some time it was used in connection with electricity, but more recently it had been found that the latter was superfluous, the introduction of the needles being all that was required. He had himself obtained good results simply with pins, by means of which he was able to set up a sufficient inflammation in the part.

DR. SHERWELL replied that Dr. Heitzmann's objections had been already met in his former paper. He was quite aware that acupuncture was old, and the only novelty about the procedure that he claimed was the introduction by means of the needles of an agent which was capable of blocking up the capillaries of the part, and the use of compression by means of collodion, which acted like a ligature, strangling the vessels which had been wounded. As to the name *tattooing*, he selected that simply because the mechanical process was the same as in tattooing proper.

\* Published in full in this issue of ARCHIVES, page 354.

DR. HARDAWAY mentioned that he had tried electrolysis with great benefit, and therefore differed from Dr. Heitzmann in his estimate of the value of electricity. Its advantages were its rapidity and bloodlessness. He was in the habit of using a number of needles in the operation.

DR. FOX said that he had employed electrolysis in one case of nævus with a fair result, but he was inclined to think that Dr. Sherwell's method was better. He considered Dr. Sherwell entitled to great credit for perfecting the details of the operation, and thought that he had accomplished wonders with the coarse and unevenly-placed needles of his rude instrument, which he had passed around. Personally, he preferred much finer needles. He also mentioned that in three cases he had tried Mr. Squire's method, and that he had not obtained satisfactory results with it.

DR. HARDAWAY, having learned that Dr. Fox had used but one needle in his electrolysis, stated that he thought that a bundle of fine needles (about No. 13), evenly arranged, of very great advantage.

DR. SHERWELL thought there might be a mechanical difficulty in using a large number of small needles, as they could not be made to enter the skin satisfactorily without more force than was desirable.

DR. WHITE said that he was happy to have the subject brought forward, as we had a great deal to learn in regard to it. He then alluded to a number of methods that had been proposed for the cure of nævi, and in speaking of that of Mr. Balmanno Squire remarked that no one had been able to obtain the same results which he claims. In two deep-seated nævi in which he had tried it it had utterly failed, and he was so disappointed in it that he never expected to resort to it again. Nor had he obtained such good results with Dr. Sherwell's plan, even in very superficial nævi, as the author himself had seemed to do. When applying electrolysis he had used but a single needle, but he had sometimes succeeded in obliterating the nævus in comparatively slight cases.

DR. HYDE had tried electrolysis in the smaller forms of nævi with great success, but not in larger ones.

DR. WHITE inquired if there had been any return of the difficulty in his cases, and learning that there had not, although some of them had been under observation for a considerable time, stated that in two or three cases of his own the nævus had returned after several months.

DR. HYDE then mentioned that in one case, which was operated on almost a year ago, a red spot had appeared after some months in the centre of the area formerly occupied by the nævus. He thought the trouble was about to return, of course, but up to the present time it had not increased in size or changed in any way whatever.

DR. SHERWELL, in bringing the discussion to a close, mentioned that the word *cutaneous* should properly have preceded the word nævi, as it was of the superficial or port-wine mark variety alone that it treated.

The report of the Committee on Statistics was then read by the

chairman, Dr. White, and accepted on motion of Dr. Wigglesworth.

DR. ATKINSON said that he thought it was worth while to ascertain whether some of the cases of leprosy in Louisiana, referred to in the report, had not been already published.

DR. HEITZMANN spoke of the difficulty of obtaining accurate statistics on account of the mistakes in diagnosis which were frequently made. He mentioned in illustration the case of a patient who was pronounced by half a dozen physicians to be suffering from leprosy, while the true difficulty was melanotic sarcoma.

DR. DUHRING also mentioned a case in Philadelphia, where five or six eminent surgeons mistook a case of tubercular leprosy for syphilis.

The report of the Committee on Nomenclature and Classification was then read by the chairman, Dr. Duhring. He said that they had to report but one important change in the classification adopted last year, which was in Class VI., where it was recommended that the positions of sarcoma and carcinoma should be interchanged with each other, and that the latter should be placed in a separate subdivision preceded by the figure 4. In Class I. attention was called to a typographical error, where comedo had been substituted for milium under the head of Cyst.

On motion of DRs. HYDE and VAN HARLINGEN, the report was accepted and the changes adopted.

DR. FOX inquired if any opportunity would be afforded during the present meeting to consider further changes in the nomenclature and classification, and expressed the desire that there should be a free discussion of the subject. Many of those who attended the meeting last year thought that the action taken was hasty, and that the matter should have been left open for at least one year, especially as some of the most active members were absent at that time. Indeed, the scheme was adopted with the statement, on the part of some of its most zealous supporters, that a thorough discussion and revision should be had at the present meeting.

The Chair having stated that no such opportunity could be afforded according to the programme that had been arranged,

DR. HYDE moved that all who desire that any changes should be made in the nomenclature or classification should report them, in writing, to the Permanent Committee, which should hereby be instructed to bring all such proposals before the Association for decision at the next annual meeting.

DR. BULKLEY seconded the motion, but regretted that discussion and action could not be taken at the present time. He regarded the previous action of the Committee and the Association as very hasty, and said that the printing of the provisional scheme and scattering it in the journals was exceedingly premature. Discussion of the subject must not be choked off, for it was of vital importance that the matter should be most thoroughly discussed, that we may arrive at a scheme which the majority can accept and use in teaching and writing, which certainly was not the case with the present one.

He had himself written recently at considerable length, commenting on and criticising the printed scheme adopted last year by the Association, but apparently no attention was paid to this by the Committee, nor to verbal suggestions by himself and others. Unless unity of thought and action was obtained in the matter, all such work was worthless.

After remarks by DRs. WHITE, SHERWELL, and TAYLOR, the motion was carried.

SECOND DAY. AFTERNOON SESSION.

DR. HARDAWAY read the first paper, entitled

**A case of multiple tumors of the skin accompanied by intense pruritus.**

The patient was a lady of 51, and the disease had lasted for twenty-two years. When seen the disease affected only the hands and the arms to the shoulders and the legs below the knees. The principal lesions were tubercles and tumors, ranging from the size of a small pea to that of a hickory-nut. When not interfered with they were covered with thickened epidermis, but this had generally been removed by scratching, which had greatly irritated almost all of them. To the touch they presented a horny feel, and some of the tumors had come together, making a large nodular mass. Most of the lesions were situated on the outer aspect of the extremities, and were as a rule symmetrical. The lesions had remained from their first appearance, and, as far as could be ascertained, no new ones had developed for at least sixteen months.

One tumor, the size of a hickory-nut, was excised for microscopic examination, and it was interesting to note that it had recurred in the same site. She had taken various remedies with little or no benefit. The case presented analogies to giant prurigo and urticaria pigmentosa, but the writer regarded it as quite unique. Microscopically, hyperplasia of both epithelial and connective tissue had been found by Dr. Heitzmann, who regarded it essentially as an inflammatory affection of the upper layers of the skin. The papillæ were remarkably slender and branching, and the deeper layers were scarcely at all affected. The great bulk of the lesions consisted of connective tissue.

DR. HEITZMANN remarked that he had never met with or heard of anything like it, and that he considered it a most extraordinary case.

DR. DUHRING asked if the tumor which had returned partook of the nature of the cicatrice or of the disease itself. To which Dr. Hardaway replied that it presented all the physical characteristics of the growth that had been removed.

In answer to a question by DR. WIGGLESWORTH, Dr. Hardaway said that so far as was known the patient had not made use of any cosmetic, nor engaged in any occupation which would affect the hands injuriously.

DR. DUHRING next read a paper entitled  
**Supplement to a case of inflammatory fungoid neoplasm.\***

The case was the one which he had exhibited at the last meeting of the Association, and whose portrait and history were published in the *ARCHIVES OF DERMATOLOGY*, January, 1879, with microscopic drawings from sections of the tumors. The history there given carried it up to October 1, 1878; from this time the patient gradually lost ground until she died, May 5, 1879, although her condition was always exceedingly variable from day to day. He expressed himself as still unable to classify the disease, and could not agree in the opinion expressed by Dr. Heitzmann that it was one of sarcoma. Full notes of the case were given, together with a detailed account of the necropsy, and further microscopical studies; sections of the tumors were also placed under the microscope for demonstration.

DR. HEITZMANN regretted that Dr. Duhring did not accept his diagnosis, since he acknowledged the truth of many of his conclusions. From his microscopical examinations in the case he determined the disease to be sarcoma, and gave an unfavorable prognosis. At the same time he agreed that there were certain very peculiar features about the case. One was the appearance of the tumors under circumstances denoting inflammatory action; another was the absorption and disappearance of the lesions; and the third, the ulceration. He could not coincide with the conclusions of Dr. Longstreth, nor was he willing to admit the correctness of his microscopical examination. The pathological process did not, according to his observations, attack the epithelium, but was confined to the connective tissue, as is ordinarily the case in sarcoma.

The assertion, in the report of Dr. Longstreth, that the disease was due to a morbid condition of the blood (in other words, that it was a blood dyscrasia), was not justifiable at the present day. Finally, he asked who had ever heard of an inflammatory affection proving fatal with such insignificant lesions, without attacking any noble organ. On the whole, he saw no reason for making any new disease of this case, but would regard it as sarcoma.

DR. ATKINSON remarked that there are connecting links between different pathological processes, and he thought that there were certain cases in which it was impossible to say definitely whether the disease were sarcomatous or inflammatory. Here the histological characters of the tumors were to a great extent inflammatory, but combined with them were those of a new growth. This was, therefore, a case which showed the border-land between the two. The lesson to be learned from it was that we ought not to mark out strict boundary-lines for nature and expect her always to keep within them.

DR. TAYLOR thought Dr. Heitzmann's view of the case was the correct one. As for the idea that this was a disease of which there were only four cases in the world, he was not willing to accept it.

\* This paper will appear in full in the January issue, with illustrations.

Diseases varied very greatly under different circumstances, and this case, he was willing to admit, was undoubtedly one of unusual exuberance of growth.

DR. BULKLEY remarked that he had seen the patient and examined the case carefully in Dr. Duhring's office, and felt assured that it was one quite peculiar and could not rightly be called simply one of sarcoma; the clinical features certainly were not those of sarcoma as we ordinarily meet with it. We were all familiar with sarcomata appearing as single isolated tumors, and as multiple to varying extent, even to that of covering much of the body, but there were other features in this case. We did not see sarcomatous growths appearing and receding so rapidly, and presenting the red surface that was noted here; he, therefore, believed that more reliance was to be placed upon the clinical characteristics than our microscopical knowledge of sarcoma, in its present state. To himself this was certainly a new disease, and he thought that if we were to pass it off merely as an ordinary case of sarcoma it would tend certainly to discourage any attempt at minute differential diagnosis, and befog the subject. The affection was undoubtedly inflammatory in its clinical as well as in its microscopical features; and it would certainly be desirable that a name should be given it which would embrace some recognition of both the sarcomatous and the inflammatory elements.

DR. DUHRING remarked that he soon satisfied himself that in its main features the case was entirely new. As to there being only four cases of it in the world, there might be others, but only four had as yet been recorded. It had been admitted that it was an affection *sui generis* clinically, but what was it histologically? He would have been glad to place it under sarcoma, but the microscopical characters were not those which he had been accustomed to recognize as that disease. The boundary-lines, however, were not so distinctly drawn as some would have us believe; but it seemed to him that the cellular elements predominated to such an extent that it constituted a strong barrier to classify it under sarcoma. Then, too, there was so little stroma in many of the specimens examined that they did not at all resemble sarcoma.

Clinically, it differed entirely from the description of sarcoma given by the best authorities; scarcely any one who had the opportunity of seeing the case would be apt to consider it of this character. Again, since two of the cases reported have occurred in Vienna, that great medical centre, and under the immediate notice of some of the most distinguished lights of the profession, including Hebra, it was at least remarkable that none of the latter recognized the disease as sarcoma, if it were that disease. There it was believed that its main features were of an entirely new character. Still, Dr. Duhring said that he would be willing to call the disease sarcoma, if the name were qualified by some term distinctive of its clinical features, and provided he could be brought to see the sarcomatous element sufficiently marked in the microscopical appearances.

DR. TAYLOR expressed the opinion that too much was being made of these minute clinical phenomena, and that the underlying condition, the infiltration of cells, was too much lost sight of.

DR. FOX thought that the present discussion was an apt illustration of the conflict between microscopic and clinical work. Some observers would err on one side and some on the other. He was satisfied that both Dr. Duhring's case and that of Dr. Piffard (which had been exhibited before the New York Dermatological Society) were both entirely different from ordinary sarcoma, and, moreover, that they were both instances of the same disease. In cases of this kind, he contended that the clinical features should be the basis for diagnosis, for when two such distinguished microscopists as Heitzmann and Longstreth differed as to the minute appearances, how could the rest of us decide?

DR. ATKINSON remarked that Dr. Duhring had certainly given us a full and graphic account of a case which was undoubtedly of great rarity, and therefore he thought that it should have a name which should distinguish the disease, for the benefit of those who came after us as well as for the present state of dermatological science.

DR. SHERWELL said, in regard to the unfavorable prognosis given by Dr. Heitzmann from the microscope, that it was pretty evident to all who saw Dr. Duhring's patient at the meeting at Saratoga last year that she would die of the disease; it did not need the microscope to learn that. He thought the name fungoid neoplasm a sufficiently good one, especially as it did not exclude the idea of a sarcomatous element.

DR. HYDE read the next paper, entitled

#### On a variety of *molluscum verrucosum* presenting certain unusual features.\*

For four or five years previously the patient noticed spots on the left buttocks the size of pin-heads, which soon spread over both thighs and disappeared after a year, but reappeared three months later. There were then a large number of variously-disposed lesions on the trunk, thighs, and legs. The newer lesions were of a dead-white color and resembled milium in general appearance, while the largest and oldest were of a delicate crimson; they were from the size of a pin-head to that of a split pea and globoid at the summit, and involved the entire thickness of the integument, with healthy tissue between. Every one of them had a waxy-white summit, suggestive of pus beneath, but only blood escaped on puncture. The disease almost entirely disappeared during the following winter, but returned with warm weather. A section had been taken for microscopical examination, but was rendered useless through an assistant's carelessness, and the disease disappeared soon after and had not yet returned.

\* To be published in full in a future issue of ARCHIVES.

DR. FOX remarked that this was a case upon which microscopic examination would have thrown considerable light.

DR. ATKINSON related the case of a young mulatto woman, which he thought at first was one of the molluscum sebaceum. On incising the point of one of the lesions, and attempting to express the contents, however, he found that he had made a mistake, and had cut into a warty growth. He then excised two of the growths, but had not yet examined them with the microscope. The patient had never returned, but he thought it quite probable that this was one of the same character as Dr. Hyde's case.

THIRD DAY. MORNING SESSION.

DR. WHITE read the first paper, upon

Etiology.

There was, he said, so much discrepancy among writers, and so many crude ideas were prevalent in connection with etiology, that the subject must still continue to invite the attention of dermatologists. Primitive beliefs have been handed down in the terms frequently employed, and he feared that physicians too often promulgated the popular fallacies and prejudices.

The chief points maintained in the paper were the following :

1. The inherent right of the skin to diseased action.
2. That the pathological processes found in the skin were identical with those met with in other parts of the system.
3. That the same methods of observation and induction which were employed in all other portions of the body were applicable to the skin also.

In regard to the autonomy of the skin, he asked, Who was prepared to deny it, *a priori*? and yet, he said, many physicians, and even dermatologists, practically did deny it in their writings and practice. There was no unanimity in the theories put forward to explain skin diseases. Ordinarily, authors were content merely to state points which they believed, and made no attempt whatever to prove them. In this connection he ridiculed the "dartrous diathesis" of the French school, which was believed to be at the bottom of almost every affection ; and yet no one else, he said, had ever been able to make out any such thing. So in England, gout was regarded as an almost universal influence in skin diseases ; but a serious objection to this was that the same diseases prevailed in localities where the "gouty vice" was unknown.

Again, one of the members of this Association had claimed that either scrofula or malaria was concerned in the origin of all skin diseases ; yet neither of these was by any means universally present. The trouble with such theorists was that they magnified mere coincidence into essential cause, and when they attempted to prove the truth of their assertions they signally failed.

In speaking of the second point, Dr. White said that almost

every one would be willing to acknowledge the unity of pathological processes in all parts of the system, and yet heretofore there had existed extreme ignorance in regard to such processes in the skin.

Under the third head, he alluded in turn to the extraordinary relations supposed by various authorities to exist between the several internal organs and the skin, and the influence of such upon cutaneous affections. In speaking of the stomach, in this connection, he mentioned that many were disposed to attribute erythematous urticaria and other affections to particular articles of food, even when they produced no digestive disturbance whatever, and expressed his disbelief in any such thing. He also dissented from the idea that acne was dependent upon indigestion, and in support of his opinion he called attention to the fact that acne, as a rule, occurred in early life, while this was not the case with dyspepsia. He also spoke of the large numbers of individuals who suffered from digestive disturbances and yet were entirely free from acne. He believed, therefore, that the association of the two was merely a coincidence. In the last two years he had made a special study of this subject, and he had come to the conclusion that acne had no connection whatever with indigestion.

The author said, in conclusion, that he had in the paper endeavored to point out some of the difficulties and errors surrounding cutaneous etiology, and expressed the opinion that we could make no real progress until we swept away all the "rubbish of superstition," and those crude theories so well calculated to mislead, and built up a system founded on the basis of observation, experience, and sound deduction.

DR. HEITZMANN remarked that it was a great consolation to his mind to hear such a paper, because he had been brought up in a school which long ago accepted the position taken by Dr. White. The connection between eczema and gout, etc., had been supposed to be conclusively proven by the character of the urine noted; yet he had found that perfectly healthy individuals often had precisely the same kind of urine, and he believed that this idea of "diathesis" was purely fanciful. Like Dr. White, he had adopted the local treatment of diseases of the skin, as practised in Vienna, and he had succeeded in curing his cases in this way. He then related the case of a gentleman suffering from psoriasis who had been told by a number of physicians that he was affected with the "gouty vice," though he had never had gout in his life. He had some dyspepsia, however, and when his diet had been properly regulated he soon got well. Very often patients who had been cured of cutaneous affections asked whether the disease would recur, and he was in the habit of always putting a counter-question to them, viz., "Suppose I cure you of a cold in the head, do you think it will ever recur?" Dr. Heitzmann said that his studies with the microscope had taught him to consider diseases of the skin from an independent point of view, but at the same time he believed the skin to be under the influence

of constitutional conditions, like the other tissues. To accuse the blood of various diatheses, however, and of being at the bottom of skin diseases, without chemical or microscopical proof, he thought absurd.

DR. FOX said that he would like to ask Dr. Heitzmann if the case of psoriasis he alluded to was not, in reality, cured by internal treatment, since he had expressly stated that he had regulated the patient's diet? Dr. White's views coincided in the main with his own. He did not believe in any diathesis comparable, for instance, to the syphilitic poison, but at the same time he could not but recognize that there were often underlying constitutional conditions present in cases of cutaneous disease, the treatment of which would hasten the cure of the latter. He had studied dermatology in Vienna, and, notwithstanding additional studies in France and England, he had been very strongly predisposed to adopt the Vienna method of treatment on his return to America. He had to confess, however, that since he had more practical experience with diseases of the skin, in dispensary and private practice, his views had changed to a certain extent. He did believe that there were some grains of truth in the popular prejudices which had so long prevailed, and in the views maintained by many of the profession, and which had been held up to ridicule.

DR. SHERWELL could not accept all of Dr. White's views, because practically he had often seen the good effects of internal treatment in cutaneous affections. He believed that there were states of the internal organs which reacted upon the skin, and which, if they did not produce disorder there, at least seemed to aggravate such.

DR. BULKLEY said that this was an enormous subject, and could hardly be entered upon in a debate like the present. He would, however, be quite willing to rest the argument for the effect of internal conditions as causing diseases of the skin upon Dr. White's own paper. In it so many points were acknowledged, such as the influence of the nervous system in some eruptions, that of the reproductive organs in the physiological changes of the skin, the effect of the ingestion of certain articles in producing urticaria, etc. All these left little to desire in the way of proof of the fact of the existence of important relations between the condition of the skin and other organs of the body.

No one denied that the skin was the subject of all manner of idiopathic affections, but at the same time it was also true that skin disease so frequently depended upon internal conditions that we could not avoid giving some consideration to the matter. He would only mention as examples the eruptions so well recognized as resulting from certain drugs,—as copaiba, quinine, belladonna, etc.; also the skin manifestations of syphilis and the exanthemata. He thought that Dr. Heitzmann's assertions in regard to the cure of diseases of the skin by external measures a little too broad, and stated that hygienic and dietetic treatment were believed to be of the highest avail by the most intelligent dermatologists of the present day. If

we cleared away all that has been done in the past, he could not but regard it as a step backward instead of forward, because it would be destroying the result of a vast amount of honest and painstaking research.

When cases came to him which had been treated by others, Dr. Bulkley went on to say, he frequently did not change the local treatment at all, but simply corrected the condition of the general system and gave appropriate medication, when they would recover under precisely the same local measures which had proved ineffectual in the hands of others. He should be very sorry to see the charge of mistaken zeal made by this Association against those careful investigators who had, as he believed, established the internal origin of certain cutaneous diseases. It was true that the correctness of such a position could not always be mathematically demonstrated, but in such a matter it was only right that all the probabilities should be taken into consideration.

DR. TAYLOR said that in the main he agreed with Dr. White, but still he had seen cases in which he had found internal treatment necessary.

DR. ATKINSON said that if Dr. White intended to imply that the skin is excluded from sympathy with other portions of the body, unlike all the rest of the organs, he could not agree with him. He must acknowledge that the skin must take part in the general morbid condition.

DR. HYPE remarked that he was much pleased with the paper. We ask for facts, he said, that will convince us that these internal conditions affect the skin.

DR. WIGGLESWORTH thought that the paper was very timely and much needed. It seemed to him that a large part of the difficulty between the advocates of external and internal treatment was due to the inability of expression,—a misconception of terms. It was the internal treatment of the patient rather than of the disease, he thought, which really took place. He regarded the skin as an organ which, being external, was exposed to influences which the internal organs escaped. It was no more unreasonable to suppose that the skin and one of the other organs should be affected at the same time than that any other two organs, such as the heart and lungs, should be diseased at the same time.

All treatment of disease was in a measure local, but, on account of its position, local treatment could be directed with greater facility to the skin than to any other organ. When, however, there was disorder of any internal organ at the same time with that of the skin, the treatment should be directed to that also.

DR. VAN HARLINGEN remarked that Dr. White's paper would have two effects: the first on the members of the Association, and the second on the profession at large. The remarks aimed at the overthrow of antiquated ideas indicated by such expressions as "driving in the disease," and others, were certainly much needed. So far as the members themselves were concerned, no one, he

thought, would treat all diseases of the skin either by exclusively local or internal remedies. While in syphilis internal medication, and in some other affections local treatment was imperatively necessary, there were others which stood on debatable ground. Personally, he would more gladly commence with the local origin of skin diseases, and from that proceed to consider their internal relations, rather than commence with the rubbish that was at present too credulously accepted by many of the profession, as well as the laity.

DR. HARDAWAY said that he was glad to see so much unanimity of opinion in rejecting the idea of diathesis and specific treatment. As for himself, he always got his best results from local measures.

DR. BULKLEY cautioned against too great a reaction in regard to the relative importance of external causes and medication as opposed to internal, and reminded those present that Hebra himself expressed very different views in the second edition of his large work, in 1874, from those given out in the first edition in 1860; further experience had developed clearer ideas. He then quoted from memory the remarks of Hebra in regard to the causation of eczema of the hands in washwomen (p. 462, 2d edition) which, in full, are as follows:

"While, therefore, we cannot accede to any peculiar or proper dyscrasia, we must, on the other hand, confirm the fact that certain conditions of the human organism, partly transient, partly permanent, at one time increase and at another time diminish its susceptibility to agencies producing eczema. These physical conditions are called a disposition, or predisposing cause, *momentum disponens*, to distinguish them from the exciting cause of irritating agencies, *momentum excitans*, and we are obliged to recognize these elements in the etiology of eczema, because experience confirms it.

"For example," he continues, "we see an eczema on the hands and forearms of a young girl who has been engaged in washing soiled linen, and we declare that the origin of the eczema is in the action of the lye, soap, hot water, and friction. Now, at the same time with this girl there are many other females washing in the same lye, using the same soap, and living under the same circumstances, without acquiring eczema. Indeed, this very girl, who now has eczema, has been exposed to the same influences previously without becoming affected. What is the cause of her present susceptibility? A careful examination of her general condition will give the explanation. The girl who before was healthy, robust, and regular in her menses, has now lost her appetite, has become sluggish and languid, her appearance is pale and bloated, her menstruation is profuse; in a word, she has become chlorotic, and thereby eczematous. The remedies suitable for the chlorosis are now employed; the appetite and power of work return, the menses become regular, and the eczema disappears in spite of the continued influences of the agencies causing it. The same observation is made in reference to pregnant and nursing women; also in those

suffering from chronic sexual disturbances. The latter must always be looked upon as favoring elements (*a momentum disponens*, or predisposing cause) which induce a *status minoris resistentiae*, and allow an otherwise ordinary skin irritant to become an exciting cause, a *momentum excitans*.<sup>1</sup>

After again claiming that we need no blood explanation of eczema, Hebra adds: "In order not to be misunderstood, we will, however, here again state that every eczema is not caused by a local irritation, but that it may be occasioned by diseases of the rest of the system." There are no grounds now for quoting Hebra as a supporter of an exclusively local origin of skin diseases.

DR. FOX said that in acne we very frequently could not cure the skin trouble until the digestive disturbance had been removed; this he held to be a demonstrable fact.

DR. WHITE, in a few closing remarks, thanked the members for their kind expressions in regard to his paper. He said that he had purposely omitted any reference to the bearings of therapeutics on the subject, as he thought that at present we were too loose in our views concerning them to bring them to bear on this question. The chief object of his paper was to show some of the errors which still existed in connection with etiology.

DR. TAYLOR then read a paper, entitled

### On the nature of syphilis.

He first attempted to prove that the various appellations which had been given to syphilis in its nosological relations, such as "a contagious and virulent disease," "a specific fever allied to the exanthemata," "a disease of the lymphatics," "a disease originating in a fungus," "a purulent diathesis," and "a blood disorder," were all more or less incorrect and unsatisfactory. His own views on the subject were as follow:

Syphilis is a disease of the connective tissue, and not primarily of the lymphatics or of the blood-vessels, although the blood may be temporarily modified and may be the vehicle of contagion. The secretions of syphilitic lesions are found to consist of a serous fluid containing numerous shining granules or molecules, which are masses of protoplasm or germinal matter, holding the contagious properties of syphilis. These microscopic bodies are probably taken into the circulation by the lymphatics and conveyed over the body. The fact that serum alone does not convey the syphilitic poison goes to prove that the corpuscles hold the contagious material.

In the secondary period these cells are very numerous, and the body may be covered with papules and tubercles composed of them. As the disease wanes these lesions become more localized and fewer in number and the blood is less contagious. Finally these cells may be limited to a few gummosus tumors; the blood no longer carries the molecules, and it loses its contagious properties. The cells no longer have a tendency to reproduction, which characterizes them

in the early stages, but rather degenerate. Hence we consider the blood and secretions in tertiary syphilis innocuous. . . . The periods of latency observed in the course of syphilis are of interest, and may perhaps be explained in the following way: Each outburst is attended by the development and multiplication of the peculiar cells, which run their course and are finally absorbed. Some remain, and after a time are excited by unknown causes to activity. Thus reflected exacerbations may occur, each one depending on the multiplication of cells remaining from a previous outburst. But each relapse is less active and prolonged than its predecessor, until, perhaps, only one nodule, and that composed of effete cells, may remain. The disease is then cured. . . .

With this view of the nature of syphilis, its effect upon the health and upon the organs and tissues may be readily comprehended. In the early active stages of proliferation the red globules are demolished and the white increased in number. The depressing influence of syphilis is thus fully accounted for: digestion is impaired and the tissues are poorly nourished. Finally, the functions of vital organs may be perverted or destroyed by the cell-changes produced.

DR. ATKINSON expressed surprise at one or two statements in the paper. Dr. Taylor, in the first place, referred to specific cells. In nature, he believed, there was only a certain kind of cells in the blood, and he could not see how any different cell could be formed. Again, he could not imagine a condition in which these cells could be so old in the body as not to be productive, if they were alive at all. Syphilis was a blood disease only in the sense that in it the blood contained syphilitic particles. We had the proof that the body never became entirely syphilitic in the fact that in many cases of inoculation we failed. If syphilitic virus were present in every corpuscle of the blood, for instance, we should expect more certainly to succeed in this; also, the entire surface of the body would be covered with the eruption, instead of the latter selecting certain portions and appearing only in spots.

DR. HEITZMANN remarked that the expression "molecules of protoplasm" was a somewhat indefinite one to him, and he would inquire if these conveyed the disease?

DR. TAYLOR replied that it was not positively known that they did, but he believed that this was the case.

DR. HEITZMANN then asked him how it was known that it was not the fluid in which they floated rather than these bodies themselves which conveyed the disease?

DR. TAYLOR replied that the fluid was simply serum, and therefore had no such power. It was assumed that it was the albuminous element rather than the watery which carried the disease.

DR. HEITZMANN then went on to say that everything in Dr. Taylor's paper seemed to be assumed, while what we wanted was proof. If we could only first demonstrate what syphilis was we might then form any number of hypotheses. Everybody knew how it was thought that the corpuscle of syphilis had been discovered by

Lastorfer, in Vienna, and how it had failed. There was no doubt that the nature of syphilis was to-day a perfect puzzle, and this paper, like whole libraries on the subject, was filled with hypotheses. That mercury was a good thing in syphilis was in reality about all that we knew definitely concerning it. How many theories had already been put forth about its nature, and yet we still went on building magnificent superstructures formed merely in the imagination. The whole mass of syphilography was at present based on a vast number of crude clinical observations, thrown together without any regard to system. The future of syphilis, however, was in the microscope, and his own studies had led him to believe that through this agency we would in time be able to make the diagnosis of syphilis as readily as that of cancer, sarcoma, etc.

In two years more perhaps he might make his discoveries known to the world, but just now he needed the accumulation of hundreds and hundreds of facts in order first to make his position sure.

DR. TAYLOR remarked that Dr. Heitzmann seemed to think that no one had studied syphilis under the microscope but himself, and that when he once took up the subject the whole matter would be adjusted without the slightest difficulty, and that all the scientific world would accept his opinions as infallible. He wished it to be distinctly understood, nevertheless, that the various points stated by him in the paper had been studied with the microscope in the most minute and careful manner by such authorities as Lancereaux, Wagner, Cornil, and many others equally distinguished.

DR. HARDAWAY read the last paper of the session, on

#### A simple method of obliterating the varicose veins in rosacea.\*

To a question by DR. WHITE, as to whether he coated the exposed portion of the needle in any way, DR. HARDAWAY replied that he did not.

DR. WHITE then inquired upon how many operations he based his results.

DR. HARDAWAY replied that the cases were comparatively few as yet; but though in some of them several months had elapsed, there had been no return of the vessel up to the present time.

DR. WHITE next asked if he ever failed to obliterate a vessel in a single operation.

DR. HARDAWAY said that in some instances he had not succeeded in accomplishing the desired result the first time, but that the second time he tried he had been invariably successful.

DR. WHITE stated that he had asked these questions because we were so much in need of a good method of treating these vascular growths. If we had at our command a positive means of obliterating the vessels, he should consider it a great advance. He would like to inquire the experience of other members in treating this condition.

\* Published in full in this issue of ARCHIVES, page 356.

DR. SHERWELL said that he had treated two cases by his tattooing method with very marked benefit.

DR. WIGGLESWORTH asked Dr. Hardaway what was the depth of the insertion, the duration of the operation, and the appearances afterwards.

DR. HARDAWAY replied that the depth of insertion was very slight, the duration of contact a few seconds only, and the appearances afterwards entirely normal.

DR. HYDE thought that the success of the operation was dependent upon the extent of the telangiectasic condition. If this were superficial, good results would be obtained; and if it were not, the reverse. So the matter of recurrence depended on the same thing. This ground had been already partially gone over in the discussion upon Dr. Sherwell's paper.

DR. BULKLEY remarked that he had not as yet employed electrolysis, but that he should be glad to give it a trial. He had had success in these cases by laying open the dilated capillary with a fine knife longitudinally, and then passing a sharp stick of nitrate of silver along the track of the vessel, and boring it slightly into its place of entering the tissues deeply. This was entirely successful if well done, but the pain was severe.

The President, Dr. Duhring, on assuming the chair a second time, congratulated the Association upon the very successful meeting just closing. The papers, it was hardly necessary to say, were very able, and the discussions most interesting, while the most complete harmony had characterized all the proceedings. He was duly conscious of the high honor conferred upon him, and he could only say in conclusion that in the year to come he should do all that was in his power to carry forward the good work that had been done in the past, and to render the Association as useful as possible.

On motion, the Association then adjourned to meet at Newport, Rhode Island, on the last Tuesday in August, 1880.

The following specimens were then informally exhibited: Microscopical sections from the cases reported by Drs. Duhring, Hardaway, and Van Harlingen; hairs presenting a peculiar nodose condition, from a case reported by Dr. Smith to the British Medical Association (see ARCHIVES, page 405); a drawing of a case of maculæ symmetrically arranged on each side of the spinal column; photographs of cases of elephantiasis arabum, severe lupus vulgaris, enormous acne hypertrophica, etc.

In the afternoon an extra clinical meeting was held at the New York Hospital, in accordance with the resolution passed the previous day, when the following rare and interesting cases were exhibited: Urticaria pigmentosa; lichen planus; "scleroderma, hemiatrophy facialis, and alopecia areata;" tubercular leprosy with rare pigmentation; lupus erythematosus; lupus vulgaris; two syphilitic cases; carcinoma of the skin; lichen ruber; and scrofuloderma, with failure of osseous development beneath the lesions.

## BRITISH MEDICAL ASSOCIATION.

## SUBSECTION OF DERMATOLOGY,

*At the Annual Meeting of the British Medical Association, in Cork, August 6 and 7, 1879.\**

The chair was taken at 3 P.M. by McCALL ANDERSON, M.D., Professor of Clinical Medicine in the University of Glasgow, who delivered the following address :

**The progress of dermatology during the last quarter century.**

It is with very mingled feelings that I rise to address you on the present occasion ; for, though deeply sensible of the honor which has been done me by inviting me to occupy the chair, I cannot forget that I am filling the post destined for one who was far better qualified than I am to preside over your deliberations ; who, by mere force of talent, rapidly raised himself to the very front rank among the dermatologists of the day ; and whose wonderful energy and perseverance, while they contributed to his success, doubtless tended to accelerate his untimely end. By the death of Tilbury Fox this Section has been deprived of the services of a most able chairman ; medical science has suffered an irreparable loss ; and we are left to mourn the separation from a valued colleague and a warm-hearted and generous friend. As has been well remarked (*Lancet*, June 14, 1879), “ He was beloved as few men are privileged to be ; honorable, upright, and conscientious in the discharge of all his duties, he lived an exemplary life. With his kindness of heart, the geniality of his disposition, and pure but unobtrusive piety, he was never so happy as when seeking out fitting objects for help, succor, and support. He did much good by stealth ; and probably not even his intimate friends knew how many poor persons at the hospital, in his private consulting-room, and in the neighborhood where he lived, partook of his bounty and benefited by his benevolence.” Our best and most useful remembrance of him will be to endeavor, in our own lives, to emulate the bright example which he has set us.

If we compare the amount of attention devoted to cutaneous medicine at the present time with that of five-and-twenty years ago, what a contrast do we find ! Then, if my memory serves me right, there were but four men who devoted themselves earnestly to the study of diseases of the skin : Erasmus Wilson, who, happily, is still among us, whose eminent services to dermatology are only to be equalled by the geniality of his disposition and his princely hospitality, and who recently still further laid his countrymen under a lasting obligation by the gift of the beautiful monolith which

\* *British Medical Journal*, August 16 and 23, 1879.

adorns the banks of the Thames ; the late Mr. Startin, whose immense experience and fertility of resource earned for him the gratitude of countless multitudes of patients ; the late Mr. Hunt, whose unfaltering testimony to the virtues of arsenic in the treatment of almost all diseases of the skin, independent of local causes and of syphilis, is too well known to meet further comment ; and last, though not least, the late Dr. Neligan, of Dublin, who had the *materia medica* at his finger-ends, and whose reputation as a dermatologist was rapidly extending when death prematurely brought his labors to a close. At that time, cutaneous medicine was at a discount, and the authorities of our general hospitals would have scorned the idea of having special dermatological departments : hence the rise and progress of special institutions for the treatment of diseases of the skin.

But, while special physicians have been appointed to treat and to further the study of diseases of the skin at the London hospitals, in most instances they have been put in a corner ; no proper accommodation has been provided for them, as if the aim were rather to strangle existing special institutions than to grapple with the subject in an adequate manner. Will it be believed that, if all the beds specially provided in connection with the cutaneous departments of the London hospitals were divided among them, there would hardly be one bed for each hospital ? If my information be correct, only two of them provide beds,—University College and the Middlesex ; while the only one which has erected a special suite of baths is the first of these, for which, I believe, we are mainly indebted to the energy and perseverance of Tilbury Fox. Indeed, the only institution in Britain, as far as I am aware, in which the requirements are fully met is the Western Infirmary of Glasgow. In this hospital, which is in connection with the great Medical School of the University, a special wing has been erected containing twenty beds, being more than those provided by all the London hospitals put together, as well as a most admirably arranged set of baths of every kind ; and, by an arrangement with the directors of the Dispensary for Skin Diseases, where out-patients alone are seen, the more serious cases are drafted into the hospital, so that the cases admitted into the wards are, for the most part, selected ones ; and thus the value of this special department to the University School is greatly enhanced. It is earnestly to be hoped that the time is not far distant when the authorities of all the great hospitals of the country will be alive to the necessity of providing, on a somewhat similar scale, for the study and treatment of diseases of the skin, as well as of the other leading specialties.

But, while this is my opinion, I desire to guard myself by adding, that I fear the tendency nowadays is towards the undue development of specialties ; and there seem good grounds for deprecating the exclusive devotion to a specialty, such as dermatology, at all events, in the case of those who have not previously gained experience of the treatment of disease in all its various forms ; for no one

can satisfactorily treat diseases of the skin, most of which are more or less connected with constitutional states, who has not a thorough practical acquaintance with the morbid conditions associated with all the organs and tissues of the body.

And here let me remark, in passing, that, for similar reasons, the system of training for consulting practice in Scotland seems superior to that in England. (Whether it is the same in Ireland I cannot well say.) In England, the physician commences his professional career ostensibly as a consultant ; he naturally aims at and ultimately succeeds in obtaining a hospital appointment ; and in process of time he hopes to become a consultant in reality as well as in name. In Scotland, on the other hand, the physician begins life almost invariably as a family physician, in which capacity he gains experience of a kind such as no hospital appointment is able to afford ; but he also secures a hospital appointment, and, as he gets experience in this twofold capacity, and earns the respect and esteem of his professional brethren, consulting practice gradually flows in upon him ; and then, and only then, he gradually recedes from family practice, and becomes a pure consulting physician. On the principle that a consulting physician is a physician who is consulted, this system may perhaps appear to some to be derogatory to the status of a consulting physician ; but unquestionably it is calculated to produce consultants more fully equipped, and more ready to grapple with every emergency, than in the case of those whose early experience is drawn exclusively from the wards of a hospital.

That increased attention is being directed to the study of dermatology at the present time, is shown by the large number of works on the subject which have recently emanated from the press ; by the journals of dermatology published of late years in Germany, France, and England, as well as in the United States, where much excellent work is being done ; and last, though not least, by the establishment of the Subsection over which I have the honor to preside, and by the number of gentlemen who have promised us papers on cutaneous diseases.

And if I were asked to state what, in my opinion, has most materially contributed to this, I would say that it is the custom, prevailing more and more every year, of young medical men, before settling in practice, prosecuting their studies for a time on the continent of Europe. In Paris they find a large hospital, with a magnificent museum attached to it, devoted mainly to the treatment of diseases of the skin, and presided over by men of the highest eminence and skill. And in Vienna they find a section of the Allgemeine Krankenhaus set apart for these diseases, and presided over by the celebrated Hebra,—a man who excites the admiration and enthusiasm of all who come into contact with him ; the practical turn of whose mind has enabled him to clear away many difficulties, to make many rough places smooth, and whose lucid and practical disquisitions are made all the more charming by the dry and sparkling humor with which they abound. If, however, we compare the con-

tinental, and especially the German, with the British school of dermatology, we have no reason to be ashamed ; indeed, it would be a disgrace if the country of Willan and of Bateman were left behind in the race. In Germany, the tendency is, I think, to trust too exclusively to external measures, some of which appear to be needlessly severe, and are apt to be resented by English people, or to be too stimulating for English skins, although we must never forget that many reputed local applications are absorbed and react beneficially through the system at large ; while in England, local is almost always combined with constitutional treatment, as it is recognized that the great majority of cutaneous affections take their origin in some derangement of the system which must be corrected if satisfactory and permanent results are to be obtained. It is, then, by a careful study of the labors of continental physicians, by borrowing from them all that is excellent in their system, while retaining all that is admirable in our own, that the English school of dermatology has reached its present high position, and that such satisfactory results are now obtained.

But while all this may be true, and while we have in Britain men of the highest eminence as our instructors,—such as Erasmus Wilson and Jonathan Hutchinson, and others who are pressing forwards to the front rank, such as our energetic and able secretaries, Mr. Malcolm Morris and Dr. Walter Smith, and many others whom it would be invidious to name,—it must be admitted that, even now, there are few branches of medicine which are, on the whole, less understood by the great mass of the profession than diseases of the skin. We look, therefore, to the authorities of our great hospitals to provide the means for the efficient instruction of our students, so that in time this reproach may be removed.

I observe that, at present, there is an attempt being made to have a special examination instituted for students on ophthalmology, distinct from that on surgery ; and, on the same principle, it may be argued that there should likewise be a special examination on dermatology, distinct from that on medicine ; but I sincerely trust that it will result in failure. By all means let them, within certain reasonable limits, be examined on ophthalmology and on dermatology, but let it be as parts of the examinations on surgery and medicine respectively, from which they should never be dissociated. Having had much experience as an examiner on medicine, I may be allowed to express the opinion that the tendency now seems to be unduly to multiply the subjects of examination ; and I am very far mistaken if the time is not at hand when the tide will turn, and when there will be an outcry for the diminution of the subjects, and a corresponding desire that the student should give evidence rather that he is well grounded in the principles of his profession,—that he should know well, rather than that he should know much.

Gentlemen,—It would ill become me further to occupy your time, which can be so much more profitably spent in listening to and in discussing the papers enumerated in the billet, and which are of a

most interesting and varied character. I trust that in the discussion, which is to be introduced by Mr. Jonathan Hutchinson, it will be made clear whether, in the opinion of the members, *lupus vulgaris* is a manifestation of the strumous diathesis, and to what extent, if any, it is influenced by antistrumous remedies; what relationship, if any, exists between it and *lupus erythematodes*; whether the latter is ever curable by internal medicines, and, if so, by which; and whether the more recent methods of local treatment—such as the use of Paquelin's thermo-cautery, Volkmann's scoops, and scarification—are preferable to caustics and other remedies whose utility has been proved by long experience.

It would be interesting and profitable, I think, if time permit, to have discussions on the nature of *alopecia areata*, and of the *impetigo contagiosa* of Tilbury Fox; also, of that disease, or group of diseases, generally classed under the name of *eczema*, and which attacks the hairy portions of the face. Is it always a simple *eczema impetiginodes*, or can its parentage be sometimes traced to *struma*, to *syphilis*, or to some other diathesis, and how should it be treated locally and constitutionally? For it must be admitted that it is often a most troublesome and obstinate affection, and requires all the light which can be thrown upon it by the most experienced practitioners.

Before sitting down, allow me to say how grateful I feel for the honor which has been done me by asking me to preside over your deliberations, and how happy I shall be if I can in any way contribute to the success of this the first Dermatological Subsection of the British Medical Association.

The first paper presented was upon

#### **Cellular growths in the skin which produce ulceration,**

By GEORGE THIN, M.D. (London).—Under this head the author reviewed some of the recent contributions to the literature of morbid growths in the skin. Passing over *lupus*, as a subject which would be fully discussed in the Section, he called attention to the disease in children which had been first described by the late Dr. Tilbury Fox and Mr. Baker in the "Transactions of the Clinical Society," and of which other instances had been observed by Dr. Barlow, Dr. Sangster, and latterly by Dr. Morrow in New York. The author showed microscopical preparations from the only case which had proved fatal. The morbid changes had been described by him in the "Transactions of the Clinical Society," but were now again insisted on, as the tendency in the latest observers was to look on the disease as a kind of *urticaria*,—the latest name given to it being *urticaria pigmentosa*. The author pointed out how inappropriate this name was, as it confounded a chronic and, so far as we yet knew, apparently incurable granulation cell-growth with a transient serous exudation involving no structural change. In the case he examined, at the time of death ulceration was only prevented

by a thin covering of epidermis over some of the patches, the subjacent *pars papillaris corii* being destroyed by this growth, and in other cases scars had actually occurred. The author suggested whether those cases were not really instances of scrofuloderma. He next pointed out the differences between the cancerous epithelial growths in epithelioma and rodent ulcer, illustrating them by preparations. Although the grouping and mode of breaking down in the cell-masses, and the condition of the surrounding connective tissue, offered usually distinctive points, yet those features were not absolutely reliable. The essential difference was in the individual epithelial cell. In rodent ulcer, the cell was characterized by a small round nucleus, single-contoured, and without an apparent nucleolus after ordinary treatment by hardening and staining agents, the cell-protoplasm being soft, yielding, and not abundant, its contours being usually lost after hardening; in the cells of epithelioma, there was a large double-contoured nucleus with prominent nucleolus and a well-defined ring of cell-substance, with a tendency to horny change, the cells being unequal in size, and even in cases in which they were small, some of them being always larger than the cells of rodent ulcer. The distinction by the presence or absence of "cell-nests" was not in all cases so reliable, although its presence in characteristic development indicated epithelioma. It was possible in hardening and mounting microscopical preparations so to dissolve and obliterate by transparency the cells of the growth that a diagnosis became very difficult.

Dr. Thin showed preparations from nine cases of rodent ulcer, four of which were prepared by himself, and five by Dr. Sangster, who entrusted them to him for demonstration.

Then followed a paper on

### Purpura hæmorrhagica,

By J. MAGEE FINNY, M.D. (Dublin).—Dr. Finny related three illustrative cases of purpura. The first was one of *peliosis rheumatica* in an elderly female, in which the cutaneous hemorrhage was most profuse, though limited to the legs. It was complicated by effusion into the right knee-joint and periosteal thickening of the left tibia. Recovery took place in a fortnight. The second was a case of *purpura hæmorrhagica* in an old man. The purpura was limited to a dozen spots, but was accompanied by bleeding from the bowels. The patient recovered. The last case was one of *purpura hæmorrhagica* in a young adult, a medical student. He had swelling oedema of legs and hands. The purpura affected the legs and wrists in uniform large patches. There were also petechiae over the thighs. He had frequent epistaxis. He recovered. Dr. Finny said that purpura was not due to diet, climate, or situation. The first cause was not in the blood nor in the vaso-motor system. The disease was a neurosis. There was no real difference, except in degree, between all the varieties of purpura. The best treatment was

at first ergot and belladonna, and afterwards bark and ammonia, or mineral acids.

The details of a case were then given which exhibited

### Hydroa after iodide of potassium,

By J. M. FINNY, M.D. (Dublin).—Dr. Finny described a case in which there was a vesiculo-pustular eruption with erythematous blush on the right half of the trunk, from the fourth rib to the ilium. There was also a similar eruption on the left side, but in small patches, one extending into the left groin and thigh. The face and back of the hands were not affected. The vesicles varied in size from a small shot to a large pea. The eruption was extremely like smallpox and herpes in appearance, but rapidly disappeared on cessation of iodide of potassium. The iodide had been taken in gradually increasing doses for some weeks before the rash appeared. The vesicles dried up and desquamated in six days, leaving no stain or cicatrice. Dr. Finny referred this strange eruption to the class hydroa, and the cause to iodide of potassium. In confirmation of this view, reference was made to Mr. Jonathan Hutchinson's report in the *British Medical Journal* for 1870, and to his report in the "Transactions of the Clinical Society of London," vol. viii.

The next paper was entitled

### On so-called hydroa,

By ALFRED SANGSTER, M.B. (London).—After alluding to the causes of the confusion still attaching to the term hydroa, the author quoted a short extract from Bazin's "Leçons sur les Affections Cutanées," describing the disease *hydroa vesiculeux*. A drawing copied from a model in the Museum of the College of Surgeons of England, representing the disease known at the St. Louis Hospital as hydroa, was shown. Afterwards, cases were referred to bearing some similarity to Bazin's hydroa, as far as the peculiar nature of the lesion present. A case reported by Dr. Marshall Hall in the *Edinburgh Medical Journal* for 1820 was quoted from; and a portrait of a similar case, placed at the author's disposal by Mr. Malcolm Morris, was shown; next, Willan's description of herpes iris was noticed, and a copy of the plate accompanying it shown. A case reported by Dr. Handfield Jones as one of hydroa was alluded to, with the latter gentleman's remarks on the development and course of the eruption present. The author reported two cases bearing upon the subject which had come under his own observation. A portrait of one of the cases was handed round. Finally, the report on hydroa in the *British Medical Journal* was referred to at some length. The conclusion drawn from the above collected cases, and from those reported in the *British Medical Journal*, was that the whole formed a series in which the chief symptom present was an erythematous eruption tending to vesicate. The latter preferred certain regions,—first in order of frequency, the back of the hands and fore-

arms. There was a tendency for the eruption to be symmetrical, although this was not constant. The character of the eruption varied according to certain unknown disturbing influences, either spreading slowly and centrifugally from primary centres and giving an appearance of discrete spots, or advancing rapidly, and causing the well-known gyrate and marginate pattern by confluence. The process appeared to vary in intensity periodically; and associated with this remittent tendency occurred vesication, either taking the form of a central vesicle or bulla, or that of a collection of closely-set vesicles on the advancing erythematous margin. Although the extremes of the series differed vastly in appearance, the whole of the cases were almost clinically identical. It was contended that Bazin's hydroa had no real existence as a separate disease, any more than the similar, if not identical condition, herpes iris; that they were both accidental developments of erythema multiforme; and that the continued use, in the substantive form, of the term hydroa was not only misleading, but illogical.

MR. MALCOLM MORRIS (London) objected to the application of the term hydroa to the forms of eruption produced by iodide of potassium, and considered that it was not necessary to give special names to fugitive manifestations of vesicular skin disease. He agreed with Dr. Sangster that hydroa was only a form of vesicating erythema.

DR. L. P. YANDELL (Louisville) would not confine the term hydroa to an eruption due to a special cause, but would retain it, and make it include a group of eruptions produced by a variety of causes.

DR. WALTER SMITH (Dublin) agreed that it was difficult to understand what was usually called hydroa, and that it was undesirable to multiply special names in dermatology.

DR. STOWERS (London) said that the eruption from iodide of potassium lasted as long as the medicine was taken. Bromide-eruption disappeared earlier, and was not affected by increase of the dose.

DR. FINNY said he was unable to give up the term hydroa. Though rare—only twenty cases being on record—it was a distinct disease.

A paper was then presented describing

#### A rare nodose condition of the hair,

By WALTER G. SMITH, M.D. (Dublin).—Dr. Smith exhibited and described specimens of a remarkable affection of the hair which had lately come under his notice. A healthy girl, aged 19, applied for advice concerning partial loss of hair, which began to fall out about four years ago without any apparent cause. Previously to that time she had always possessed a good head of hair, reaching down to her shoulders. The hair was uniformly thinned over the whole scalp, and the longest hairs measured about five inches. Upon close inspection, a singular appearance was noted. Nearly all the shorter hairs presented a regular succession of swellings along the

shaft, one nodosity corresponding, on an average, to one millimetre of length of hair. The eyebrows were thin, but no beaded hairs could be detected either among them or in the eyelashes. The axillary hair was scanty, but normal; and on the pubes one hair was found with three of the characteristic fusiform swellings. The microscopical characters of the affected hairs were very remarkable, and were illustrated by drawings and specimens. There was scarcely a trace of scale-imbrication on the nodules; but it was tolerably well marked in the contracted portions. Brown pigment was deposited outside the axis in streaks, much more abundantly in the nodes; and thus each hair, viewed by the naked eye, presented the appearance of being checked alternately brown and white. There was no trace of cells in the axis of the nodules. No account of this curious condition had hitherto been published; but Dr. R. Liveing had a similar case under his charge some years, the details of which were given in the paper. Dr. Walter Smith took occasion to point out that these nodose hairs exhibited no evidence of any fungoid elements, and that they could not be confounded either with piedra or with the tricosyphilis of Wilson. From trichorexis nodosa, with which it might be supposed they had affinity, they differed in several particulars. 1. There was little tendency to partial fracture of the cuticle, or brush-like splitting of the cortex. 2. The nodose hairs occurred in multitudes on the scalp. 3. When a hair was broken, the fracture was usually clean, not fibrous, and occurred through a constriction, never through a node. 4. The nodes were opaque, and constituted the darkest parts of the hair. 5. The nodules were very numerous, and succeeded each other in regular order like beads on a necklace.

DR. MCCALL ANDERSON (Glasgow) had examined the hairs, and found they were not parasitic. Though trichorexis nodosa was rare on the head, yet he was familiar with it in that situation. He thought that this condition was closely allied to trichorexis nodosa, though not exactly the same.

DR. FINNY (Dublin) asked if the nodose alterations were observed at the distal ends of the hair, in reference to the point whether the cause was intrafollicular or not.

MR. MALCOLM MORRIS (London) said that trichorexis nodosa, in his experience, was very rare on the head, and suggested that the nodose appearance in the hairs might be due to atrophic change at periodic intervals; the swollen parts of the hair representing the normal diameter of the shaft, and the constrictions the atrophied portions.

*Thursday, August 7.*

The next paper consisted of

#### Notes on the treatment of ringworm,

By WYNDHAM COTTLE, M.A., M.B.Oxon. (London).—Having noticed the ready curability of ringworm in infants, and when situ-

ated on parts not clothed by a vigorous hair-growth, Mr. Cottle was led to believe that the difficulty experienced in eradicating the disease depended on the *materies morbi* having found shelter in the deep hair-follicles, etc. He has observed that ringworm rarely survived suppuration in its site, as when a pustular rash supervened ; the products of inflammation partially reacting and destroying the disease in its deep follicular seats. He endeavored to imitate artificially this curative action of nature by applying substances inimical to fungoid growth, and also capable of exercising the requisite action on the skin. His earlier attempts were made with the sulpho-carbolate of barium and zinc, and with some success. They were, however, often slow in causing suppuration, and sometimes failed to do so. More satisfactory results were obtained by painting the affected parts with croton-oil liniment, and subsequently applying, two or three times daily, an ointment of ten to forty grains of salicylic acid to an ounce of lard. Suppuration was readily produced, and the amount of irritative action could be regulated by the strength and vigor of the applications. Other drugs, as antimony chloride, salts of mercury, zinc, etc., can often be combined with the salicylic acid with benefit. The advantages of this method of treatment are : 1. It gives rise to no pain and but little inconvenience. 2. No permanent loss of hair results. 3. It is easy to carry out. 4. Many intractable cases rapidly mend when so dealt with. 5. The agents are not poisonous. Such active measures are not required in recent cases of ringworm in healthy individuals, and are unsuitable where scalp irritation exists. The requisite constitutional treatment should also be employed. The following points seem worthy of consideration in dealing with ringworm : 1. The risk of the extension of the disease should be avoided. 2. Suitable constitutional treatment should be adopted. 3. Almost any of the usual remedies suffice to end the recent disease in healthy individuals. 4. In chronic and obstinate cases, the use of croton-oil liniment, followed by the application of salicylic acid either alone or in combination (or of any other agents whose action is similar), offers a not unpromising means of eradicating the disease.

MR. MALCOLM MORRIS (London) distrusted the constitutional theory of ringworm, and placed his reliance on careful and persistent local treatment.

DR. THIN (London) remarked that all the best means of curing ringworm acted on the common principle of exciting inflammation, and that constitutional causes operated by influencing the mode in which the caustic or other irritant acted.

DR. STOWERS (London) thought that Coster's paste was the best local application.

MR. FILSON (Portaferry) suggested that the fact of cases of ringworm being cured after cessation of all local treatment, might be due to the remote rather than to the immediate effects of the topical remedies.

DR. L. P. YANDELL (Louisville) considered that, under suitable

circumstances, ringworm was easily curable. A popular remedy in America was burnt paper; another was the juice of the walnut.

DR. MCCALL ANDERSON (Glasgow) was in the habit of employing caustic in obstinate cases. Local remedies were either stimulant or parasiticide; and the greatest care should be exercised in guarding against auto-infection. There was nothing specific in the action of any of the parasiticides, but every case did not bear the same treatment.

#### Notes on the neurotic origin of lichen planus

were then read by T. COLCOTT FOX, M.B. (London).—The author's object was to redirect attention to the neurotic origin of lichen planus, a disease which was now well known to dermatologists, but which had long baffled their observation as to its true causation. Having quoted authors to show that either not any cause at all was made out, or only nutritive and digestive disturbance, Dr. Colcott Fox referred especially to the definite statement by Dr. Tilbury Fox ("Skin Diseases," third edition, 1873) as to its neurotic causation, and also to the similar suggestion by Mr. Hutchinson ("Clinical Lectures," 1879). The author first alluded to his own observation of nearly thirty cases, in confirmation of a history, precedent to the rash, of worry, anxiety, nervous depression, and disturbance of the sympathetic system. Secondly, he pointed out that the eruption is not of an inflammatory nature, as described, but is simply a chronic neuroparalytic hyperæmia in localized areas, with its effects. Thirdly, he quoted two cases he had met with, in which there was a remarkable distribution of the eruption in a band on the inner aspect of the leg, from the thigh to the malleolus. And, fourthly, he took occasion to place on record a case of lichen planus which passed into the lichen ruber of Hebra.

The next paper was upon

#### The use of arsenic in skin diseases,

By ROBERT FARQUHARSON, M.D. (London).—About thirty years ago, the British Medical Association issued a series of queries to its members, with reference to the use of arsenic in skin disease; and, considering the somewhat haphazard way in which the drug was then used, it was no doubt necessary to reassure the public mind, as was effectually done by the replies, that its use was at all events not attended with danger. We know now much more precisely in which cases to prescribe the remedy with good effect; and the question naturally arises, How do we explain the undoubted fact that, whilst arsenic frequently relieves and even cures certain forms of cutaneous disorders, at other times it appears to be inert or even to do harm? It has been supposed by some authorities that, following up the analogy of the vesicular and pustular eruptions which form an occasional, though rare, part of its physiological action, it

simply acts as a cutaneous irritant, by stimulating sluggish processes of repair ; or, again, we may hold that it effects some alteration in the blood, through a general influence on cell-growth ; or, thirdly, and most suggestively, we may seek for our clue in the regions of nervous pathology. We know that eczema and psoriasis and lichen, etc., often show their neurotic origin in heredity and symmetry, and itching and tingling ; they not uncommonly appear in connection with mental shock and depression ; and may alternate with, or accompany, such undoubtedly nervous disorders as chorea. Arsenic is generally held to be a nervine tonic, and, speaking generally, we find it to be a useful and reliable remedy in all the skin affections of the dartrous class (Clifford Allbutt). In pemphigus it acts almost as a true specific (Hutchinson). It is most valuable in lichen ruber, and has been recommended as an antidote to bromide acne ; although the question might arise, whether the arsenic in any way lessens the restraining influence of the bromide over the epileptic fits. Over impetigo, strumous and syphilitic diseases, it has no influence ; and it would be interesting to note its effect on herpes zoster, which has been reported as occasionally following its administration.

Concerning the mode of administration, the author preferred to begin with a full dose of ten minims to fifteen minims, and push boldly on, believing that, as with quinine and iodide of potassium, troublesome physiological symptoms are here more likely to follow small quantities than large. Some authorities strongly insist upon the necessity for producing some conjunctival and gastric irritation before we can obtain the full curative influence of the drug ; but the author was opposed to this, believing these symptoms to be an unnecessary addition to the discomfort of the patient. When they do arise they need not cause any alarm ; but the sickness which sometimes follows each dose of the medicine is quite a fatal obstacle to its use. It is important to see that the natural elimination of the drug is not checked by any renal obstruction ; and Dr. McCall Anderson warns us that patients, under the influence of arsenic, are specially susceptible to cold. May it not be, however, that the bronchial irritation occasionally observed may really be due to the curative influence of the remedy causing metastasis to the pulmonary mucous membrane ? The liquor arsenicalis seems to be, on the whole, the best preparation ; the liquor sodæ arsenitis being, in the author's experience, in no degree less irritating. Children will bear large doses with impunity ; and although it is generally held that girls can take more than boys, the only case in early childhood in which it had been found seriously to disagree belonged to the female sex. Finally, it may be asked, Can we really *cure* chronic disease with arsenic ? and the answer must be in the affirmative, if we get our case early, treat it systematically and carefully, continue the use of the drug for some time after the skin has become clear, and remember the importance of good food and air, and mental and bodily rest.

A paper was then presented upon

### Erythema nodosum,

By CHARLES F. MOORE, M.D. (Dublin).—Dr. Moore began by giving a description of the condition and surroundings of the cases of the disease that he had seen. 1. A sailor lad aged 16, on one of his first voyages to the Mediterranean, had lately left his home on the shores of a muddy estuary. 2. A married woman lived in a house permeated with the odor of sewage, which flooded the yard in a narrow street in Dublin (September, 1868). She was nursing a strong child several months old. 3. A girl aged 12, living in a back room on the first floor in a poor locality, also suffered from pains in the ears and chest, with dyspnœa and palpitation. 4. A boy aged 8 suffered much from restlessness. 5. A girl aged 7 had also an old skin-disease of the scalp, discharging matter; she suffered from shivering, febrile symptoms, gastralgia, and foul tongue. 6. A boy aged 13, delicate, with a fair complexion, had also diarrœa and much debility. This boy, who lived in a top back room, had pain "under the shoulders." The spots were recurrent. Dr. Moore, some time afterwards, heard that this lad died of disease of the kidneys, of which disease his father also died a little time subsequently to his son's death. 7. J. B., a girl aged 9, had white tongue, was "always over the fire," and suffered much from pain in the legs. 8. C. L., aged 23, lived on the ground-floor in a back street. He had the nodes on the legs and shins, and also had rheumatism. He was a weakly-looking young man, and complained much of the offensive condition of the house in which he lived. 9. In M., a boy aged 8, the elevations were described as "purpuric looking." 10. L. F., aged 6, lived in a court that was a *cul-de-sac*, the sanitary condition of the place being very bad. The child was strumous, with tumid abdomen, muscles generally flabby and feeble. The weather (June) being hot, rendered the surroundings of this child doubly unwholesome. 11. E. B., aged 8, lived in an unhealthy locality. The nodes were on the anterior aspect of the legs chiefly; there were smaller tumors also on the arms and shoulders; none on the abdomen. In 1868 and 1869, when ten of the preceding eleven cases were seen, there was also a prevalence of herpes zoster. In 1873, also, erythema nodosum was rather common. 12. C. McC., aged 7, was born and reared in comfortable circumstances in the county of Cork, but had been lately living with her parents and their several other children in a small room in Dublin, within a few yards of the river Poddle, the locality being as a rule severely visited by epidemics when prevalent. She was seen by Dr. Moore in June, this year, for several patches of erythema nodosum upon the anterior surface of both legs. Her little brother of four years had enteric fever, and a little sister of two years had bronchitis. After a succession of nodes on the legs and knees, C. McC. had, on July 26, pretty well regained her health. Early in July, she also

had pain in one ear and a cough, and had been passing very little urine. Erythema nodosum, in the author's experience, occurred far more frequently in children than in adults, and as often in delicate boys as in girls. Debility from defective sanitation or bad food from childhood, from nursing, appeared to predispose to it, as did that state of the blood that disposes to rheumatism, erysipelas, and glandular affections. Exposure to cold also seemed to favor its occurrence. A decided febrile state mostly marked some part of its course; and possibly attendant on the same, or more probably as a sequel, renal troubles appeared to occur; at all events, not very rarely. So far as Dr. Moore's recorded observations went, the disorder did not show a necessary connection with the state of the uterine functions. Analysis of the renal secretion would appear a useful field of observation in this interesting disease, which, in Professor Hebra's experience, invariably ended in recovery.

The next paper related to

### Scarification as a remedy in skin disease,

By MALCOLM A. MORRIS, F.R.C.S. (London).—After stating the advantages to be gained from surgical interference in certain skin diseases, Mr. Morris described the mode of treating port-wine marks, as advocated in a pamphlet by Mr. Balmanno Squire, published in 1876. He then gave the notes of three cases treated by scarification during a long period, all of which were unsuccessful. In one case, the operation had been performed one hundred and thirty times, but with no improvement; in fact, rather the reverse, in consequence of the formation of a keloid growth. Mr. Morris then went on to give the reasons, in his opinion, why the process was a failure; remarking that, as the minute scratches healed so rapidly by first intention, the continuity of the vessels was not destroyed, and so no alteration in color could be produced. He then passed on to other diseases treated in a similar way, and gave three instances of acne rosacea, in which multiple linear scarification had produced marked benefit. He also thought it was of considerable use in certain stages of lupus erythematosus.

Dr. McCALL ANDERSON was struck by the successes in Mr. Squire's paper, and, after a trial of his method, came to the same conclusion as Mr. Morris, viz., that the method was valueless in the treatment of port-wine mark.

The discussion on lupus was introduced by the following paper, on

### Lupus: its nature, varieties, and treatment,

By JONATHAN HUTCHINSON, F.R.C.S. (London).—In Mr. Hutchinson's unavoidable absence, Mr. Malcolm Morris read the paper by him, introducing the discussion. Mr. Hutchinson described lupus as a disease characterized by infective cell-growth, limited to the skin or mucous membrane, and only by accident involving deeper structures; in this respect differing from "malignant" disease.

Its alliance with common inflammation was shown by similarity of exciting causes. It was wholly independent of syphilitic taint, though it might be closely simulated both by acquired and by inherited syphilis. There was, however, good reason for associating it with scrofula, to the state which produced diseases of the psoriasis type, and to the condition of feeble circulation which favored the occurrence of chilblains. Mr. Hutchinson regarded lupus as not a specific nor even a well-specialized disease. It did not always preserve identity of type, nor acknowledge identity of parentage.

The diagnosis of the varieties of lupus from each other was usually easy; but sometimes it was impossible. The author discarded the old division of lupus into *exedens* and *non-exedens*; these terms simply distinguished the destructive lupus of the nose from the lupus of flat surfaces, although the process was the same. He then described the characters of *lupus erythematosus*, distinguished especially by its tendency to symmetrical development, and including as varieties *lupus sebaceus*, *lupus erythematosus hæmorrhagicus*, and a rare form closely resembling nævus. Of *lupus vulgaris*, the following varieties were described: single-patch lupus; many-patch lupus; ulcerating lupus; acne-lupus; eczema-lupus; and lupus marginatus. Lupus of the mucous membranes was also alluded to. In the treatment the remedies indicated were tonics, good food, bracing air, cod-liver oil, and the judicious use of stimulants. Arsenic might also be usually given with much advantage. Iodides and mercury must be avoided. Local treatment, to destroy the new-cell growth, was also necessary. Mr. Hutchinson had had much experience of the use of caustics, the actual cautery, and Volkmann's erosion method; and he unhesitatingly preferred the last of these.

A paper was then read upon

#### The use of the iodide of starch in the treatment of *lupus erythematosus*,

By McCALL ANDERSON, M.D. (Glasgow).—After remarking on the obstinate way in which this affection resists internal remedies, Dr. Anderson stated how he was first induced to try the administration of the iodide of starch, it having been employed with the most happy results by Dr. Colligan, of Paisley, in a case in which all the ordinary remedies failed to make any lasting impression; and Dr. Anderson now regarded it as a valuable addition to our means of combating this most obstinate disease. The following is the formula for its preparation: R.—Iodi, gr. xxiv; amyli, ʒj. Triturate the iodine with a little water, gradually adding the starch and continuing the trituration till the compound assumes a uniform blue color, so deep as to approach black. The iodide should be dried with a heat so gentle as to run no risk of driving off the iodine, and it ought to be kept in a well-stoppered bottle. On no account should spirit be used in its preparation instead of water. The dose is a heaped-up teaspoonful in a draught of water or water-

gruel thrice daily; but it may be safely increased even up to an ounce in some cases. In using it, care must be taken, first, that the cases are really undoubted cases of lupus erythematosus and not lupus vulgaris; and, second, that the medicine is freshly prepared, and in accordance with the directions above mentioned.

The next paper was entitled

#### On the treatment of lupus by linear scarification,

By BALMANNO SQUIRE, M.B. (London).—The treatment of lupus by pricking the skin at short distances with a pointed instrument was long since advocated by Dubini, of Milan, and subsequently by Volkmann, of Halle. The author had devised an improvement on this plan, namely, by cutting the skin into thin strips by means of a many-bladed instrument which he had contrived, and which has been constructed by Messrs. Weiss, of London. The Dubini-Volkmann method (known as multiple punctiform scarification) has been highly successful. The author's method (termed multiple linear scarification) has, he said, proved still more successful. It has been tested and commended in this country by Dr. Walter Smith, of Dublin, and Mr. Malcolm Morris, of London; while in Paris, at the Hôpital St. Louis, Dr. Vidal and his assistants treat every Wednesday as many as from forty to fifty patients by the author's method. The advantages are the same as those which attend punctiform scarification, namely, the setting up of a traumatic inflammation under which the disease heals; but the superiority claimed for treatment by closely and regularly spaced incisions is a more rapid and at the same time a more complete cure of the disease than can be effected by means of irregularly distributed punctures. Dr. Vidal had observed, in sections of the skin thus healed, the gradual conversion of the lupus-cells into fibrous tissue. The advantages of treatment of the disease by the excitement of traumatic inflammation as compared with other means of treatment were described in detail as being less painful, as causing less loss of substance, and as leaving less permanent trace of its performance than the customary methods of local treatment, viz., the application of caustics or semi-caustics.

The last paper presented was upon the general subject of

#### Lupus,

By J. HERBERT STOWERS, M.D. (London).—He first spoke of the original misunderstandings produced by the confounding of the three affections now long since known to be separate and distinct, viz., lupus, cancer, and syphilis. After urging that the term "syphilitic lupus" should be entirely discarded, as likely to mislead, and pointing out the essential origin of true lupus to be a constitutional defect of strumous nature, while admitting local injury to be an occasional exciting cause, the writer proceeded with several observations upon the pathology of the affection bearing upon the investigations of Virchow, Friedlander, and others. Concerning the frequency with

which this disease occurs in practice, after reviewing the statistics of Dr. White, of Harvard University, published in the Transactions of the late Philadelphia Medical Congress, the author stated that his own experience in hospital practice during the last four years showed that fifty-eight cases of lupus occurred in two thousand two hundred and ninety-six general skin-patients, or about two and one-half per cent. Of these (agreeing with the observations of Devergie and Mr. Jonathan Hutchinson that lupus is more common among females), thirty-six were females and twenty-two males, the ages of the patients commonly ranging from fifteen to thirty years. In a table giving full details of thirty-two cases of which full notes were taken, including the respective ages at which lupus first showed itself, Dr. Stowers stated that the face or neck was affected in each of thirteen females presenting simple or non-ulcerating lupus, and in three out of seven males; in each of the six females with ulcerating lupus, as well as the three males; and also that the face was the seat of the disease in the three females having lupus erythematosus. Besides the above, lupus was observed once on the forearm, three times on the hand (dorsum), twice on the dorsum of the foot, and once on the thigh and prepucce. After several observations upon the nature and pathology of lupus erythematosus, Dr. Stowers referred to the investigations of Dr. Thin, published in the Royal Medical and Chirurgical Society's Transactions, in which the latter concluded that no changes antecedent to the capillary congestion are discoverable, and that the affections of the sebaceous and sweat glands should be considered rather the consequence than the cause of the congestion.

DR. L. P. YANDELL (Louisville) was convinced that lupus in its various forms was a thoroughly scrofulous disease, and was curable by constitutional means alone.

MR. MALCOLM MORRIS said that his experience led him to believe in the association of lupus with scrofula or tubercle. He laid stress on the necessity of constitutional treatment, at least in the first instance. As to local treatment, the method of linear scarification gave undoubtedly good results, and for severe cases the method of scraping was the best. For small isolated nodules, the best way was to forcibly bore out the morbid tissue with nitrate of silver.

DR. WALTER SMITH preferred, as a rule, to begin at once with local treatment. He had tried both erosion and scarification. In some situations—*e.g.*, on the tip of the nose—erosion was not easily applicable, and scarification was preferable. He mentioned a case of lupus of the face of twenty-five years' standing, which had been under surgical treatment for a length of time, and in which erosion proved highly successful.

DR. MCCALL ANDERSON believed in the scrofulous affinities of lupus, and was accustomed to prescribe internally cod-liver oil and phosphorus. Local treatment alone was not completely to be relied on, even if the local manifestations of the disease were stamped out.

A vote of thanks to the chairman concluded the business of the Subsection.

## DIGEST OF LITERATURE.

### I.

#### DISEASES OF THE SKIN.

##### GENERAL TOPICS AND THERAPEUTICS.

EDWARD B. BRONSON, M.D.

**Guinea worm disease.**—Dr. TILBURY FOX, shortly before his death, contributed to the columns of the *Lancet* a series of “unusual or rare forms of skin disease.” Among them was one of the Guinea worm disease, an affection but little known in this country. The patient, a young lady, was first seen by Dr. Fox three months after the first appearance of the symptoms of the disease, and eleven months after her return from India. The disease began as an inflamed spot on the outer side of the foot. It was at first supposed to be a simple boil, but, instead of suppurating like a boil, a whitish blister appeared in the centre, which, being pricked, gave exit to a watery fluid. The surrounding parts became sore and of a somewhat livid hue; there was a discharge and considerable pains, especially at night. One morning, about a month after the commencement of the disease, the patient noticed something that looked like a piece of thread or worsted protruding from the wound, and which moved about. This was cut off, but the following day it had appeared again, and again the next, and on each following day for about a week, when a physician managed to extract the worm (which the little thread proved to be) entire, and the part then healed rapidly. Subsequently another spot of redness, with some swelling and tenderness, appeared in the sole of the foot, but afterwards shifted to the inner side, just below the ankle. The inflammation occupied a space as large as the palm, showing in the centre a circular livid spot “the size of a shilling,” which was bounded by a loose frill of cuticle, and in the middle was a little elevation as large as a split-pea. The patient was treated with assafoetida, according to the plan proposed by Dr. Horton. In five days the worm had extruded itself to the extent of an inch and a half, and the following day it was found lying in the poultice that had been applied. It measured  $23\frac{1}{2}$  inches.—*Lancet*, March 8, 1879.

**Congenital disease of the skin.**—A very curious family history is recounted by Dr. Fox. The father and mother were, to all appearance, perfectly healthy. There was no suspicion of syphilis. Six children were born. Three of these were living and healthy. One died on the sixth day after birth. In this there was a total absence of skin above the knees. In other respects the development appeared normal. Two other children are described as follows: The first was a girl, 6 years of age. She was delicate-looking and small. The disease from which she was suffering had existed from birth. At first only the hands were affected, however; the rest of the body appeared normal. Upon the back of the right hand was a bulla, and on the left was a "red sore," similarly situated, where a bulla had been. A little later there was a general eruption of pemphigus bullæ over the body, some of them transparent, some with bloody contents, and after bursting, sores were left. The child soon became emaciated. The skin was easily rubbed off by slight knocks, leaving excoriations. Bullæ were occasionally developed in the mouth. The fingers became contracted and deformed. The condition of the child when first seen by Dr. Fox is described as follows: "The patient was slightly emaciated, the sensibility of the skin was unimpaired, and here and there on the surface was a bulla. The whole skin of the forehead was thinned and shining, as if a simple inflammation had been followed by decided atrophy; the nose was sunken at the root; the eyes were weak; the teeth late in development, atrophied, but not decayed; the tongue bound down to the floor of the mouth, and there were white patches along the gums; the skin of the arms was shrivelled slightly, as if xerodermatous, that of the elbow almost ichthyotic; the hands looked as if strenuously inflamed and deformed, the backs tense and shining, the knuckles prominent and enlarged, the fingers cramped together, the finger structures tense, the nails gone, and the whole aspect claw-like. The thighs were dry and almost ichthyotic; the legs like the arms; the feet dry and scaly, and webbed together from the healing of adjoining raw surfaces; but the feet were not otherwise distorted; the nails were absent."

The other child, which was two years and three months old when examined, was also born with bullæ on the body, and the eruption had continued ever since. It was weakly and unable to walk. The general development of the body seemed to have been retarded; the throat was sore and ulcerated; bullæ occurred on the tongue, leaving slight ulcerations; the body "looked as if blotched all over with fading psoriasis, and the skin was thick and stained; the sole of the foot was the site of a warty patch from the root of the toes to the heel; the nails come and then fall rapidly."

The pemphigus in these cases is regarded by Dr. Fox not as the essential disease, but simply as an expression of the defective energization due to the general mal-development of the skin.—*Lancet*, May 31, 1879, p. 766.

**Perforating ulcer of the foot.**—A paper on this disease was recently read before the Medical and Chirurgical Society of London by Drs. SAVORY and BUTLIN. In it they conclude, from certain symptoms which almost invariably accompany perforating ulcer, from their examination of the leg after deaths in two cases, and from reports given in other papers, that the disease is due to central or peripheral nerve lesions, especially affecting the sensory, trophic, or vaso-motor nerves.

In the discussion of the paper, Prof. Humphry remarked upon a possible connection between *corns* and the disease under consideration, observing that in every instance a corn seemed to be present at the seat of the ulcer. While accepting the theory that a nerve change was the cause of the disease, he would suggest that the prolonged irritation of the corn might be the source from which the nerve disease first originated.

Mr. Barwell opposed this view, on the ground that the disease did not occur where corns were most common, on the back of the little toe, but where they were very rare, in the sole of the foot.

Dr. Duca claimed that in many features the disease bore a close resemblance to changes met with in anæsthetic, and sometimes in tubercular, leprosy. He had seen ulcers in this disease occur in the sole of the foot and penetrate to the bone.

Dr. Thin maintained that in leprosy there was a new-cell growth which invaded the tissues and destroyed them, which was not the pathology of the disease in question. Mr. Gaskoin observed, however, that some writers had mentioned new-cell formations as occurring in the affected nerves in this disease, which would tend to bear out the supposition of an affinity between the two diseases.—*Lancet*, April 5, 1879, p. 477.

**A substitute for iodide of potassium.**—Dr. W. GILL WYLIE, of this city, in a communication to the *Medical Record*, claims that in bronchitis, and in chronic or subacute catarrhal diseases, he has found hydriodic acid to be equivalent in its therapeutic effects to the iodide of potassium. It was first prepared by mixing one drachm of iodide of potassium with ninety grains of tartaric acid, and dissolving in four ounces of water. One teaspoonful of this mixture, it is claimed, had as much effect upon the bronchial surfaces as twenty grains of the iodide, and produced no bad effects on the stomach. But hydriodic acid in a watery solution is an unstable preparation, and very liable to decomposition. To obviate this it was mixed with a thick syrup which could be kept for several days. A syrup containing forty minims of the dilute acid to the ounce is recommended. Two teaspoonfuls was the average dose. It is suggested that the iodide of potassium owes its activity to conversion into hydriodic acid. The writer had had no experience with regard to the action of his remedy in syphilis.—*Medical Record*, 1879, xv., p. 454.

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## NEW FORMATIONS.

EDWARD WIGGLESWORTH, M.D.

**Treatment of nævus by sodium ethylate.**—Sodium ethylate, used since 1871 by Dr. T. BRUNTON, is prepared by adding the metal sodium piece by piece to absolute alcohol in a wide-mouthed bottle; when effervescence ceases, a crystalline substance,  $C_2H_5NaO$ , has been deposited at the bottom of the flask.

Dr. Richardson has the credit of bringing this and other alcoholic and ethylic derivatives into notice in 1870. He says "when it is brought into contact with water it is decomposed, the sodium becomes oxidized by the oxygen of the water, forming sodium hydrate, the hydrogen of the water going to reconstitute the common or ethylic alcohol. The change of ethylic alcohol into sodium alcohol transforms it from an irritant to a caustic. Laid on dry parts of the body the sodium ethylate is comparatively inert, but as soon as the part to which the substance is applied gives up a little water the transformation described above occurs, caustic soda is produced in contact with the skin in proportion as water is eliminated, and there proceeds a gradual destruction of tissues, which may be moderated so as hardly to be perceptible, or may be so intensified as to act almost like a cutting instrument."

It is therefore valuable for the destruction and removal of malignant growths beyond the reach of the knife, by application to the surface or by subcutaneous injection into the growth. Upon the unbroken skin only slight pain is caused, quickly checked by the

addition of chloroform. These alcohols dissolve opium also, suggesting to Dr. Richardson the possibility of a sure, rapid, and painless caustic. Caustic alcohols may be used in combination with local anaesthesia from cold. Thus, with ether-spray and the subcutaneous injection of caustic alcohol, we have a valuable means for treating a poisoned wound, such as snake's or mad dog's bite. So possibly for cystic tumors.

Potassium and sodium alcohol dissolve in the volatile hydride of amyl, producing a caustic solution. Applied to the skin the hydride evaporates, the caustic remains. Compared with the action of nitric acid there is less destruction of epidermis and less pain, and hardly any scarring, the action of the ethylate being limited to the spot where it is applied.—*Lancet*, Nov. 2, 1878; *Amer. Journ. of the Med. Sciences*, Jan. 1879, p. 262.

**Treatment of nævus with sodium ethylate.**—Dr. B. W. RICHARDSON says that the ethylates are sometimes called alcohols, because in them the atom of hydrogen which in alcohol is, with its radical, combined with oxygen, is replaced by an atom of sodium or potassium. He treated in 1870 a small nævus on the neck of a child two years old with sodium ethylate. This nævus was cured by six applications of the fluid, and a sound surface left. Soon afterwards another as large as a half-dollar and quite prominent was treated in the same manner. The application gave very little pain. The nævus soon turned dark. In three days a firm, hard incrustation had formed. A few days later this was dry enough to be lifted up. The nævus had been reduced in size. Sodium ethylate was again applied as at first, and so on till the nævus was removed and a natural surface left. Time required, nine weeks and three days.

**Practical Notes.**—In making the ethylate of sodium, which is the most manageable, it is best not to make much at a time. Put half a fluidounce of rectified alcohol (sp. gr. 0.975) into a two-ounce test-tube, set the test-tube up in a bath of cold water, and add in small pieces at a time some cuttings of pure metallic sodium. A gas, hydrogen, will at once escape. Add the sodium until the gas ceases to escape, then warm the water in the bath to 100° F., and add a little more sodium. When the gas again ceases to escape, stop the putting in of more sodium ; or, if crystallization takes place, then stop. Afterwards cool down to 50° F., and add half a fluid-ounce more of alcohol. This will give a good working solution, which can be made more active by adding sodium, or less active by adding alcohol.

Put the solution in a glass-stoppered bottle, and have the bottle always well closed. Keep the bottle always in a cold place. Once a bottle of the ethylate, left during summer-time exposed to the sun in my laboratory, exploded, so that the bottle was broken and the contents spilled.

Always apply the ethylate with a glass rod. The ethylate solution must not be mixed with other fluids than alcohol. Mixed with

chloroform in quantity a violent action is set up, and the ethylate is decomposed into chloride of sodium and an ether,—triethyllic.

The ethylate is not so manageable for subcutaneous injection as for application to the surface by the glass rod. It especially deserves trial in lupus, in malignant ulcer, and in vascular cutaneous growths and excrescences.

The addition of an alcoholic solution of opium lessens the pain of an application.—*Lancet*, Nov. 9, 1878, p. 654; *Braithwaite's Retrospect*, Jan. 1879, p. 246.

**Erectile tumor from scalp.**—A tumor projecting  $3\frac{3}{4}$  centimetres from the surface of the scalp, somewhat thickened at the free end, with an offensive odor where it was ulcerating, and of six months' growth, was removed by Dr. S. W. GROSS.

On making a longitudinal section through the tumor, and after staining it with carmine and indigo, it was found, on microscopical examination, to present a picture very similar to that of a longitudinal section of a small penis.

The base was found to be composed of the normal tissue of the scalp; the shank, or narrow portion, of cavernous or erectile tissue, the meshes of which were lined with endothelium and filled with blood-corpuscles; while the gland-like expansion at the free end showed, at first glance, glandular tissue. A more careful examination, however, proved this tissue to be the same as that of the shank, but with the endothelial cells of the caverns in an active state of proliferation, and a return to the foetal state. The whole of the tumor was covered with a thin layer of epithelium, except at the extreme end, where it had been destroyed by ulceration. By the ordinary processes of staining with one color, the distinction between glandular tissue and this cavernous tissue, filled with proliferating cells, could not easily have been made; but by employing the double staining, which colors the nuclei red, while the intercellular substance is tinged blue and the blood-corpuscles green, it was readily seen that in between the oval cells numerous green blood-corpuscles were impacted.

This specimen shows the value in pathological histology of large sections, and of the double staining process.—*Phila. Med. Times*, May 10, 1879, p. 386.

**Erythematous lupus of nose and laryngeal mucous membrane; œdema of glottis.**—BERINGIER reports the case of a priest, scrofulous at birth, having double pneumonia at the age of eight years, and subsequently feeble health. His nose was attacked by lupus in his twenty-third year; soon afterwards his voice altered so that all preaching had to be given up. At the age of twenty-seven he suffered during six weeks from perfect aphonia, since which time the voice has been hoarse. At the age of thirty the patient showed (November, 1877) on each side and at the back of the nose a flat, bluish-red patch, sharply defined, not sensitive to the touch, covered with fine whitish scales. Improvement after cauterization

with chloride of zinc. Velum and arch of palate covered with transparent granulations like wheaten groats. These were repeatedly touched with tincture of iodine. Early in April, 1878, without apparent cause, severe aphonia again supervened, with chills and fever, anorexia, and difficulty in swallowing. Even soup was swallowed with difficulty and vomited with coughing. Difficulty of breathing prevented the horizontal position, though not causing suffocation. There was soon complete aphonia. After protracted blistering over the hyoid bones there was general improvement, though ten days later the patient was still hoarse.

At the time of the attack there was, to the finger, marked swelling of the epiglottis and ary-epiglottic folds, and the laryngoscope showed marked inflammatory swelling of the mucous membrane of the arytenoid cartilages. Right false vocal cord much swollen, covering the true one, of which the free edge only could be seen by phonation. Lower left vocal cord visible, red, and covered with miliary spots. At the junction of the posterior third with the two anterior thirds of this last, corresponding to the anterior extremity of the proc. vocal. aryt., there was an elevation due to severe hypertrophic inflammation at this point. The epiglottis, ary-epiglottic folds, and right false cord took less part in the inflammation. The writer regards this as a transient œdema of the glottis due to lupus of the mucous membrane of the larynx accompanying the lupus of the mucous membrane of the nose.—*Ann. des Malad. de l' Oreille, etc.*, iv. 3, p. 172, 1878; *Schmidt's Jahrb.*, Bd. 181, No. 2, April 22, 1879, p. 139.

. **Lupus erythematosus.**—HUTCHINSON regards lupus as a chronic inflammation of the skin, attended by a cell-growth in the deeper layers, which spreads slowly at its edge, and thus involves adjacent parts, which inevitably disorganizes the parts attacked, and always, after cure, leaves a scar. It is by this tendency to leave a scar that we separate lupus from psoriasis, for after the cure of the latter the skin is left quite sound. Now the lupus process is in part one of new growth, and in part one of inflammation, and it varies, no doubt, not alone in reference to the temperament of the patient, but also in respect to the precise tissue in which it originates. The alveoli of the corium are its usual site, but in different cases the sebaceous glands, the papillæ, and the vascular system may be disproportionately involved. There are forms of common inflammation in which paralytic dilatation of capillaries is the chief feature, and others in which cell-multiplication is greatly in excess of the increase in supply of blood, and we recognize precisely the same modifications of the lupus process.\*

There is also a form of lupus in which the tendency to vascular dilatation is so conspicuously in excess of the other factors in the inflammatory process that a special name has been given it. Under

\* There is also a rare form of cancer of the skin, usually secondary to cancer of the breast, in which the capillary dilatation is a very conspicuous phenomenon.

the name *lupus erythematosus* observers have denoted a malady closely allied to *lupus*, indeed, in many cases, absolutely identical with it, but of which the chief feature is an erythematous patch. This patch proves its nature by its long persistence, the slow spreading at its edge, and by its always leaving a scar when the morbid process ceases. There is exceedingly little evidence of cell-growth, at any rate in many cases, but there is always some; it is not that one part of the *lupus* process is wholly omitted, but rather that another takes the lead. In some instances the vascular dilatation is extreme, and a condition closely resembling *nævus* is produced, whilst in a few a tendency to rupture of vessels is observed, and a *lupus erythematosus hæmorrhagicus* is constituted. These extreme forms are rarely seen excepting in young children. The more common forms of erythematous *lupus* are met with, however, not in children, but in young or middle-aged adults, and are attended by much less peculiar conditions. Usually the disease begins on the nose, and a red, slightly roughened patch is produced on the middle of that organ; next, two symmetrical red patches are seen on the cheeks (seldom continuous at first with that on the nose), and after a time patches occur on both ears. The tendency to symmetry is very remarkable; the patches are independent, and not continuous. Although erythematous *lupus* spreads at its edge, and is serpiginous, just like other forms of *lupus*, yet it differs from all other forms in its marked tendency to symmetrical development. Next to the ears come the backs of the two hands, and it is very rare indeed to see one hand alone, or one ear alone, affected. Often the cheeks are affected before the nose, and not unfrequently the ears before either, but usually the order of production is as stated. When the patches on the cheeks have become joined to that on the nose, a form is produced like that of a body with wings, which has been compared to a bat's wings or a butterfly.

There are other minor features of peculiarity by which we recognize this disease: the patches are usually abruptly margined, more red at their edges than in the middle, rough, dry, slightly scaly, and seldom attended by any crust; often a great number of little patches occur in a cluster, some of them becoming confluent, and, when this is the case, the little patches, which are more or less round, are depressed in the centre and slightly raised at the edges, being what is known as disk-shaped. These disks are reckoned by some authorities as the characteristic feature of the disease, but they are by no means always present, nor is it always easy to distinguish them from those of common *lupus*. On some parts, and in certain cases, the surface of the patch shows a great number of little pits, which are the orifices of sebaceous glands made conspicuous by the shrivelling up of the surrounding skin, and by the presence (often) of little dried plugs of sebaceous matter. These conditions are most often seen on the nose, but frequently on the cheeks also, and they probably occur to those whose skins are naturally somewhat coarse, and whose sebaceous glands are large and sluggish. In most cases these

two conditions of roughness with pitting and erythema are present together, but in a few there is scarcely any erythema. To these latter the term *lupus sebaceus* was formerly given by some. This term might, perhaps, be retained for convenience, but the two are really parts of the same morbid process, which receives minor modifications in connection with the age and temperament of the patient.

Such, then, are the general features of erythematous *lupus*. It is a disease usually easy to diagnose. Those not familiar with its appearance would probably mistake it for chronic eczema, for a slight form of psoriasis, or for common *lupus*. From eczema the history usually distinguishes it at once, the patient saying probably that he has had the patch exactly in its present position and state, getting little either better or worse, for years. Eczema, on the contrary, is either cured or spreads quickly. The peculiar positions affected, and the forms produced, are facts also of great value in diagnosis. But above all, one must look for the scars. If one finds that the disease is spreading at the edge and healing with a thin but definite scar in the centre, the diagnosis is complete, for neither eczema nor psoriasis\* ever do this. We are not much concerned to establish the diagnosis from common *lupus*. In most cases it is easy enough; and when it is not, then it is impossible, and the attempt irrational, for the two run into each other. The presence of tubercles or of thick masses of new growth, the tendency to ulcerate and to scab, and the non-symmetrical arrangement all definitely denote common *lupus*. Whatever is symmetrical, and affects at once, with separate patches, ears, cheeks, and nose, is probably of the erythematous variety.—*Med. Times and Gaz.*, Jan. 4, 1879, p. 1.

**Treatment of lupus.**—Dr. PIFFARD reports several cases of *lupus* treated by excision, scraping, or actual cautery, or by a combination of these means. Thorough and radical treatment is insisted upon; every *lupus* cell must be destroyed. We must seek to replace the lesion by a cicatrice, to prevent a relapse *in situ* and the development of the disease elsewhere. This is best done by excising or scraping away the *lupus* tissue, and then employing the galvanic or other actual cautery. Internal remedies are of value only as benefiting the general health of the patient. Scraping followed by the actual cautery is the least painful of the radical operations proposed, and cicatrization is most rapid, the resulting scar being smooth and less disfiguring than that following spontaneous involution or the potential caustics. Success depends upon thoroughness in operating. Relapses *in situ* occur usually in three months; elsewhere they may appear later. Here constitutional treatment is very necessary.—*Med. Record*, April 5, 1879, p. 315.

**Lupus.**—VIDAL, at the Hôpital St. Louis, treats non-ulcerative forms of *lupus* by oil of cashew nuts externally applied with friction

\* Perhaps an exception should be made for certain very rare forms of psoriasis.

every three or four days, or by Hardy's formula of aq. dest. 30, potassii iodidi 8, iodinii 3 to 4 parts. Stronger still is a caustic glycerole composed of ten grammes of glycerin to five each of iodine and iodide of potassium, applied every second day on cloth and covered with gutta-percha. The pain is severe for two hours, and all of these plans leave scars. Paquelin's thermo-cautery or iron at a red heat is better where much destruction of parts is called for. Best of all is surgical treatment, aided by frequent poultices to remove crusts (contrary to the opinion of Bazin), and powdering with iodoform after the crusts are removed. Lailler uses iodoform dissolved in ether to avoid the smell of the drug. This is especially valuable in ulcerations within the nasal cavities. The treatment by the scraping-spoon is admirable, but relapses occur from "scraping the hills and leaving the valleys untouched."

An even more beautiful cicatrice may be obtained by means of scarifications. Local anaesthesia is produced by salt and ice or ether, which also hardens the tissues so that they cut more easily. Then the spot is scarified to a "broth." The tubercles are softer than in syphilis. There is not much bleeding. Blotting-paper alone is needed. The pain is gone in less than two hours. Subsequent swelling needs only cold-water compresses. In three to four days the inflammation disappears. It is then to be renewed by a plaster of biniodide of mercury and fat, equal parts. In six or eight days the scarification must be repeated. The point of the instrument must penetrate to sound tissue.

The best results are obtained in the tuberculous and ulcerative forms.

When the lupus is a patch, peripherally extending, the circumference is of course the chief point of attack, and it should be thoroughly destroyed. Scarifications must be repeated eight or ten times, until, in fact, there are no more little tubercles apparent in the cicatrice. The cure then lasts perhaps for years, or should a tubercle appear in the interim, it must be at once attacked. The cicatrice is soft, smooth, and barely apparent. Scarifications have been made with good results upon the palate and gums, but the crayon of nitrate of silver is preferable.—*Gaz. des Hôpitaux*, No. 35, March 25, 1879.

**Combination of lupus and carcinoma.**—In the Vienna Medical Society KAPOSI showed, Nov. 8, 1878, a patient upon whose left arm, well covered with lupus nodules, there had developed during the last few months a cancerous mass twice the size of the fist. This was the third case of the sort he had encountered. Such have been reported also by Hebra, Volkmann, O. Weber, Wenck, Lang, and Esmarch. The tumors had been characterized in most of these cases by rapid growth and an early-developed cancerous cachexia.

Cures by operation had been reported by Hebra, Volkmann, and Esmarch, but the majority of the patients had speedily succumbed.

The patient shown had been relieved of his tumor by Prof. Dittel by means of the elastic ligature and galvano-caustic, and had spent forty-four days and nights in the water-bed, under which treatment the slough had been speedily cast off. A nodule appeared after a few days, and was destroyed by Hebra with caustic potash. Luxuriant and rapid granulation followed, and when exhibited the wound was level with the parts around, contracted and covering itself with sound skin.

The question arises, How does a process vegetative in character, now disintegrating, now reorganizing, chronic in course, slowly destructive and hardly affecting the general constitution, give rise of a sudden to a locally, rapidly destructive and constitutionally dangerous formation? Does the structural nature of the lupus furnish opportunity and foundation for the development of carcinoma owing to some histological relationship? This is hardly supposable in the case of the common well-marked lupus. We have to deal in these cases with the worst form of epithelioma, the malignant papilloma, in which the peculiar epithelial development plays histologically and hystogenetically a special rôle. Kaposi, like Billroth, Gussenbaum, and Stricker, adopts Virchow's view, that cancer cells may arise from connective-tissue corpuscles, formed elements of the walls of vessels or muscle cells, but that, as the rule, the formative tissue of the characteristic epithelial proliferation of cancer is given, as Thiersch teaches, in the pre-existent epithelium of the rete and of the glands of the skin. This is proved anatomically and chemically. Opportunity for cancerous development exists wherever hyperplastic epithelium is naturally present or pathologically produced, or proliferating epithelium is from local or general cause interrupted in its natural growth changes. Cancer comes thus from papillary or pigment warts, from syphilitic patches upon the buccal mucous membrane, upon chronic ulcers of the feet, etc., as well as from lupus.

Epithelial hyperplasia in cases of lupus is twofold in its nature. One would be of normal type, as shown in preparations exhibited, where upon and between the greatly enlarged papillæ rose, like a tower, the enormously developed rete, and layer upon layer of horn cells. The rete has here developed according to its own nature, though lupus-nests are still present in the cutis, probably because the cutis, cicatrically thickened, offered a barrier to the progress of the epithelial proliferations. From such a warty lupus a carcinoma might of course arise. Kaposi had, however, never seen such a case.

But there is a second form of epithelial proliferation in cases of lupus, furnishing naturally an opportunity for cancer growth. The rete proliferations branch, intertwine, and build an epithelial network into the lupus tissue. This is the picture of epithelial cancer, except that the epithelial cells are still normal. More marked proliferation forms, and an onion-like disposition of the cells alone is needed to make the cancrum.

The anatomical relations explain the rapidity of growth of a cancer upon a lupous foundation, and the danger of metastasis and

cachexia. In common superficial epithelioma, inflammation and cicatrization impede the growth of the epithelial cells, the cancer exfoliates and spreads peripherally into the still normal and succulent skin. With lupus the proliferating and developing epithelium meets a tissue exceptionally softened and debilitated by the lupous inflammation, penetrates it very easily, and the cancer growth is rapid.

Therapeutically, Kaposi adheres to his views of the great value of pyrogallic acid (10 to 100) for the painless destruction of superficial and infiltrated carcinoma, pushing it to rapid and complete extirpation where epithelioma exists upon a lupus on account of the speedy renovation of such a formation. The value of arsenic internally administered is doubtful.

Hebra added that it was interesting to see that the water, in the forty-four days and nights spent by the patient in the continual bath, had produced no effect upon the lupus. The relapses also of the new formation had been very rapid, requiring excessive and intense cauterization. He had given, without benefit, up to 300 grains of arsenic in cases of new growths.—*Wiener Med. Presse*, No. 3, Jan. 19, 1879.

**The larynx in cases of leprosy (elephantiasis Græcorum).**—Dr. C. C. RICE reports two cases of leprosy occurring at the Charity Hospital, New York, in the clinic of Dr. Elsberg for diseases of the throat. The first was a boy of 19 years, born in Santiago, Cuba, where he lived for nine years; since then in New York. Four years ago the prodromata appeared as malaise, somnolence, cephalgia, chills and fever, and pains in the bones. A year later, brownish-red indurated lumps upon the cheek; no progress for two years. Then tubers appeared, generally upon the face, the eyebrows fell off, and the "leonine" countenance developed itself; a few scars on body; limbs dark, desquamating, with spots of ulceration and anaesthesia; voice husky; tongue swelled and fissured; tubers on uvula; palate and pharynx free; epiglottis thick and congested; tubers covered its free margin; the ary-epiglottic and ventricular folds and the arytenoid cartilages show the presence of tubers; general health fair.

The second case, a man of 45 years, lived in New York until 32 years of age, then spent three years in Santiago, Cuba, and the last ten years in New York again. Prodromata in February, 1878. In March tubers on the face; face now "leonine;" legs brown and scaly; ulceration of fingers and toes; nails gone; ulceration of palato-glossal and palato-pharyngeal folds; ozœnic catarrh; epiglottis tumefied, its free edge thick and irregular, with angular lateral boundaries; ary-epiglottic folds and ventricular bands enlarged, congested, and uneven, covered with a few large and many smaller tubers; arytenoid cartilages and posterior halves of the vocal bands masked by the new growths,—these bands are of a dirty-yellow color; one large tuber on the inter-arytenoid space.

The three forms—lepra maculosa, tuberosa, and anaesthetica—occur as stages merely in the laryngeal disease. The first pathological change is vascular injection, then in spots there is loss of epithelium, infiltration in places, and hypersecretion. The infiltrations tend to ulcerate, and may then cicatrize, causing form-changes of various parts of the larynx, and even stenosis. The disease is here to be distinguished from lupus syphiliticus. The prognosis of laryngeal leprosy is always unfavorable. The voice cannot be restored. Treatment: cleansing spray and soothing local inhalations. A diluted emulsion of gurjun oil (balsam dipterocarpi) is highly praised as a local and internal remedy. A saturated solution of iodoform in sulphuric ether has proved grateful. The laryngeal stenosis may call for tracheotomy.—*Med. Record*, Jan. 4, 1879.

## RECENT LITERATURE.

## NEW FORMATIONS OF CONNECTIVE TISSUE.

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## HÆMORRHAGES AND NEUROSES.

ARTHUR VAN HARLINGEN, M.D.

The diagnosis of contusions from spontaneous extravasations in scorbutic disease, and from erythema nodosum.—Dr. SCHEBY-BUCH contributes a brief but interesting article on this subject, in which, after calling attention to the fact that the diagnosis of these affections is important, and at the same time frequently by no means easy, he goes on to state the principal points to be noted. With regard to the external appearances, among those observed in the extravasations of scorbutic disease every variety of lesion may be met with, from the smallest pin-point petechiae to great patches of ecchymosis, and extensive suggillations with every intermediate size. No single one of these lesions is found alone, but there is always a variety of sizes and shapes. This

point is of importance in the diagnosis from contusions. The favorite seat of spontaneous extravasations is on the lower extremities, where also they reach their greatest development. The larger suggillations most resemble contusions, but they are most likely to occur in the subcutaneous and deeper connective-tissue strata, and are even observed in the muscular structures. They are chiefly found on the limbs, and particularly under the tendo-achilles, on the anterior surface of the tibia, the popliteal space, the axilla, the extensor surface of the forearm, and under the scalp. These extravasations may be larger than the fist, are of very various consistency, and pass through the well-known mutations of color. This latter characteristic is of importance in differentiating spontaneous extravasations from the lesions of erythema nodosum, since these latter do not always change color to the same extent.

Traumatic extravasations are not to be distinguished in appearance from the spontaneous lesions just described. They are more apt, however, to occur in exposed situations, but this may also happen with the spontaneous extravasations. The fact which has been observed, that the traumatic lesions are softer in the centre, cannot be relied upon as pathognomonic. The most important point in the diagnosis of extravasations lies in the condition of the skin which covers them, which, in the case of traumatic lesions, is apt to be abraded, or the seat of ulceration. Even this is not absolutely decisive, and when present the closest examination is often required before a positive conclusion can be reached. Of course, when an injury to the bone beneath a lesion can be made out, the diagnosis is not difficult. The so-called blood-blister often found above extravasations have, however, no diagnostic value.

It is an important fact that these ecchymoses are accompanied by swelling of the surrounding connective tissue to a greater or less degree, not only in well-marked scorbutus, and to some extent in purpura haemorrhagica, but also even in purpura simplex. The fact is, that these affections are not well defined, and occasionally are found running into one another. When, in an otherwise healthy individual, pin-head-sized maculae together with larger ecchymoses are found, while the gums and mucous membranes are unaffected, the affection is to be reckoned as purpura simplex. From a forensic standpoint these points are of much interest if mortifying mistakes are to be avoided.

The diagnosis between extravasations from contusion and those found in purpura haemorrhagica and well-marked scorbutus is more readily made, the involvement of the gums, together with the bleeding from the nose, ear, rectum, and genitalia, in the latter cases showing that the individual is suffering from a haemorrhagic process.

The general condition of the patient is important. Not unfrequently in spontaneous extravasations the individual is apparently in good health, and here this throws no light on the subject. But in other cases there is the history of a haemorrhagic diathesis, or of some other malady.

Scheby-Buch regards the post-mortem appearances as of more importance than either the local or general symptoms during life. When, however, we come to examine what he has to say on this subject, we find that in reality the appearances presented post mortem are not more pathognomonic than those observed during life. Of course this fact is important, but chiefly from a medico-legal point of view. After noting several cases our author says that on the whole, between spontaneous hemorrhages due to scorbutic disease, and those resulting from contusions, only one certain distinction exists, which itself, unfortunately, is often absent,—that is, that the instrument with which the injury was done shall have left traces upon the surface.

In the examination of doubtful cases, one should first ascertain whether the individual has suffered from any affection which might be connected with scurvy, or if any scorbutic symptoms are present. In all of Scheby-Buch's cases of scorbutic trouble, characteristic small petechiae were invariably found on the skin or mucous membranes in connection with the large, doubtful ecchymoses. He urges that the gums, etc., should always be examined.

Contusions may readily be mistaken for erythema nodosum, and vice versa; the very name, erythema contusiforme, formerly given this disease, points to the resemblance. Erythema nodosum is usually found upon the lower extremities, less frequently upon the trunk and upper extremities. It may be found upon the face,—a fact of importance,—though in twenty-one cases observed by Scheby-Buch it was not observed there. Whether it may occur on the scalp or not is not known. The fact that changes of color are frequently wanting in the lesions of erythema nodosum, and that these sometimes pale and fade away entirely without change of color is, as was before remarked, significant. Further, the fact that the lymphatics in the neighborhood of the lesions of erythema nodosum are frequently enlarged and easily perceptible may serve to aid in the diagnosis. This last symptom is not usually noted in the books. The neighboring joints are also apt to be swollen and painful to a greater or less degree. Erythema nodosum occurs in otherwise healthy individuals, so that etiology does not lend much aid to diagnosis. It usually occurs in multiple form; rarely is but a single lesion observed. [We have abstracted Scheby-Buch's article at some length because of its eminently practical character. Exact observations like these, which add something to our diagnostic knowledge, are of permanent value. We have been obliged to omit reference to certain parts, e.g., the post-mortem appearances, as belonging more particularly to the department of medico-legal investigation; but the original article is well worth perusal.—REP.]—*Viertl Jahrschr. f. Derm. u. Syph.*, vi. Jahrg. S. 89.

**Purpura hæmorrhagica in a patient who had suffered seven years previously with scurvy.**—Dr. BOZENET speaks of the close resemblance between scurvy and purpura hæmorrhagica and the occasional difficulty in their diagnosis. Two fundamental

and constant symptoms are common to both, namely, the eruption of haemorrhagic maculae and multiple haemorrhages. However, the more rapid course of the affection in purpura; the fever, almost always absent in scorbutus, the cause, usually more obvious in the latter; the fungous condition of the gums, very rare in the former, have seemed sufficient to authorize their description as two distinct entities. Bozenet, with some other authors, regards purpura and scorbutus as two forms of a single disease,—forms nearly identical in physiognomy and treatment, and the result of a diathesis of which purpura realizes the acute expression and scorbutus the chronic. This accidental haemorrhagic diathesis, this general fragility of the capillaries, results from mal-nutrition of these vessels by vicious and insufficient elements. It is distinguished by its transitory character from haemophilia where the haemorrhagic diathesis, dormant or active, is permanent. In the case given by Bozenet, where the same individual had, with an interval of seven years, suffered from both forms of the accidental haemorrhagic diathesis, the various shades of difference between the two attacks were perceptibly marked.

The case, *en résumé*, was that of a soldier who had suffered during the siege of Paris, in 1871, with well-marked scurvy. Seven years later, his health being rather delicate, he had walked a long distance in the cold, through snow. After four days of prodromal symptoms, malaise and headache, purpura, characterized by a violent attack of haemorrhage from the ears, gums, and pharynx, together with a profuse skin eruption of haemorrhagic maculae, appeared. The petechiae appeared in daily crops; the haemorrhages, at first active, as was indicated by the hot and painful enlargement of the cervical veins, quickly became passive and incoercible. The patient's condition became worse up to the sixth day, when very rapid amelioration took place. At this period a benign gingivitis of scorbutic appearance showed itself, which was not cured until a month later. This retarded but did not arrest the patient's convalescence. Treatment by means of perchloride of iron completely failed; ice, on the other hand, gave an immediate and good result. A gargle of quinine also appeared to be of great benefit to the gums.—*Le Concours Médical*, July 12, 1879.

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